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Medical Journal

Vol. 78, No. 1, January 1982

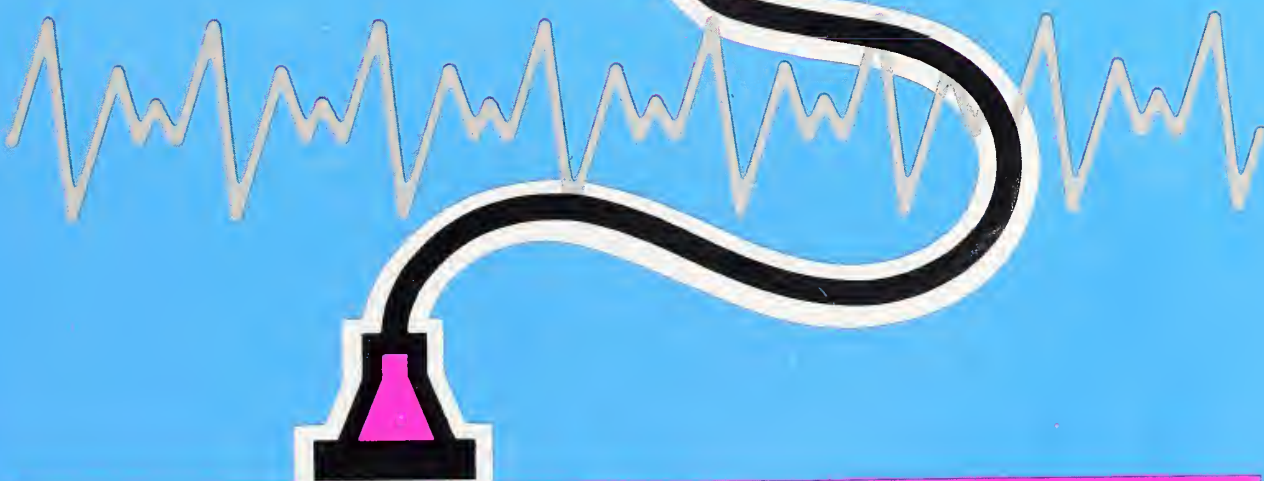
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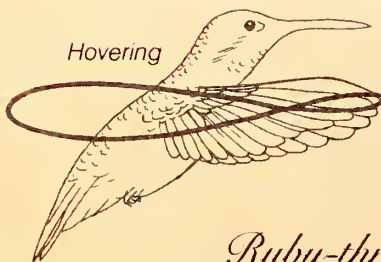
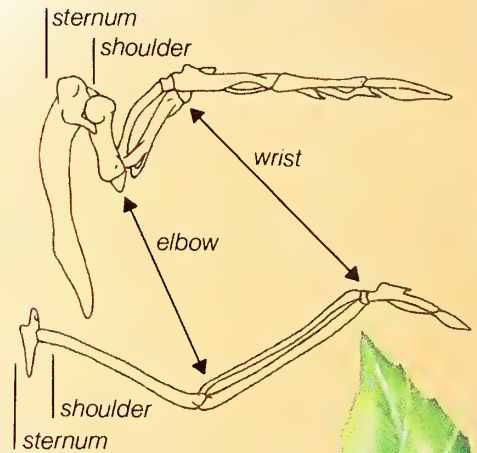
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One of nature's most distinctive designs...

Compared with a typical bird wing (lower drawing), the "hand" portion of the hummingbird wing (upper drawing) is greatly enlarged, while the elbow and wrist are small and rigid. Maneuverability occurs only at the shoulder. This structure actually permits the hummingbird to hover and fly backwards like a helicopter.



Ruby-throated Hummingbird
(*Archilochus colubris*)



THE **Ohio** STATE Medical Journal

(ISSN 0030-1124)

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**Practice Management:
Minding your own
business**

This issue of the Journal provides some tips, hints and sound advice on the best way to manage your practice. Running your own business isn't always easy, but the experts who have authored these articles show you ways to make the job less complex, and, as any of them will tell you, the rewards of managing a well-run practice are worth the effort it takes. So read on. As you'll soon learn, it's good practice to mind your own business.

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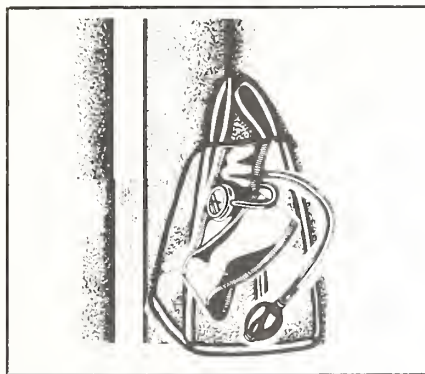
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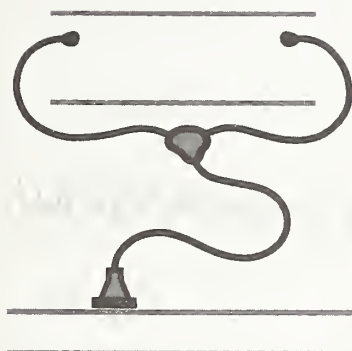
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600 South High Street
Columbus, Ohio 43215
Telephone: 614/228-6971

Address All Correspondence, Address Change, & Reprint Request (unless otherwise noted): Executive Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215. Phone: 614/228-6971.

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1981 Subscription: \$15 per year, single copy \$2 (outside U.S. \$20 and \$3).

Send address changes to: The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second Class Postage paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

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(ISSN 0030-1124)

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Physician Suicide 75

This AMA report takes a look at the increase in physician suicide, and what the AMA, in conjunction with the American Psychiatric Association, intends to do about it.

**Breast Cancer. Selecting a
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What is it really like to serve as ship's doctor aboard a "Loveboat"? A Dayton physician recently asked the physician who practices aboard the "Queen Elizabeth II."

**OMIM's Participating
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A personal Decision 104

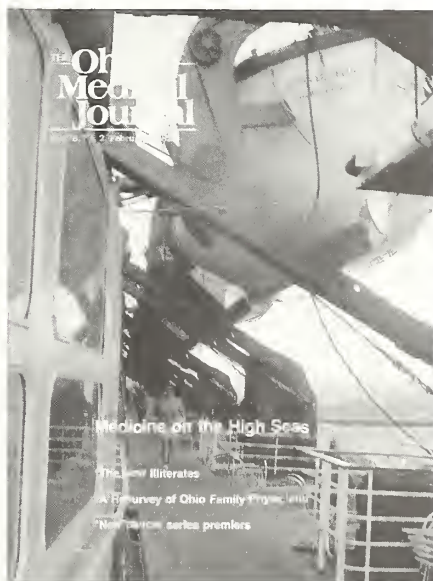
The decision to enter into a participating agreement is a decision which each physician will have to make for him or herself. This article examines the issues involved and provides some advice for those faced with the decision.



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Taking exercise aboard the Queen Elizabeth II is just one way to spend time on a cruise ship. Gordon S. Walbroehl, M.D., who furnished this photo, as well as the story which begins on page 99, takes a look at how a ship's doctor spends his time on the QE II.

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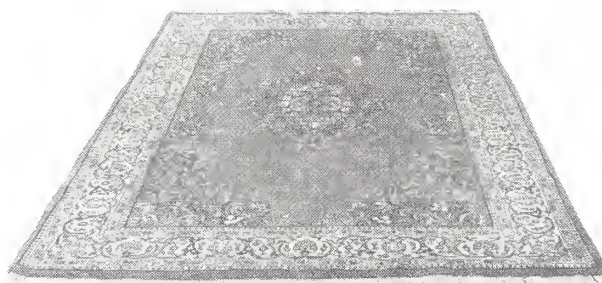
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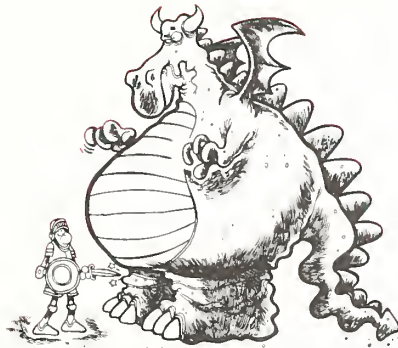
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Rebecca J. Doll

A look at the Ohio State Medical Association's newest member benefit.



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The 1982 OSMA Annual Meeting 247

What's in store for those attending the 1982 OSMA Annual Meeting in Dayton, Ohio? This special section provides all the answers.



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Louis Saslow

The OSMA's Student Section recently held its first Annual Meeting. This article details the Minutes of that Meeting, and those Resolutions which the Section passed.



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Our Cover

"Expanding Horizons. The Wright Way in '82" is, of course, the slogan of this year's Annual Meeting to be held in Dayton, Ohio April 30-May 5. The logo on our cover was designed specifically for this year's Meeting by Sergei Itomlenskis of Itomik Design Studio.

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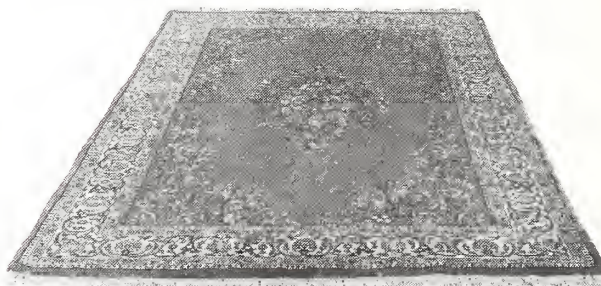
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Gordon S. Walbroehl, M.D.

A look at National Health Service and British health care, through the eyes of an English physician.

The Media Tamer 331

Karen S. Edwards

When a crisis occurs, someone has to handle the vital communications link, and sometimes that person has to be a physician. Here's how one physician handled himself — and the media — through such a crisis.

Personality Styles and Antidepressants 337

Gregory G. Young, M.D.

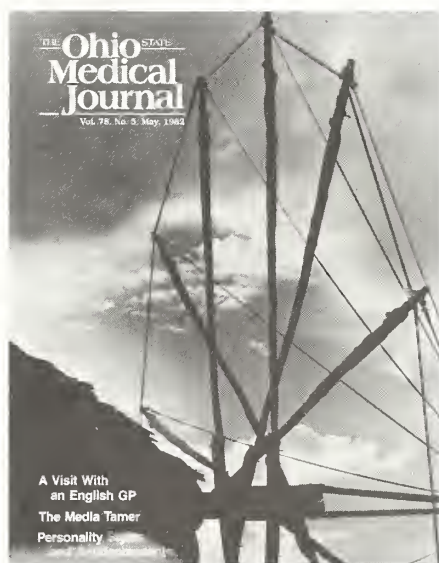
This study examines individual personalities and how they respond to different antidepressants and dosages.



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Our Cover

Judith Weidenthal, a previous winner in the OSMA Journal Photography Contest, took this picture of a windmill in Greece. Next month's cover will feature one of the "Outstanding Entries" from the 1982 Photo Exhibit Contest.

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Clinical and Scientific

Neonatal Hypothyroid Screening in Ohio 360

Antoinette P. Eaton, M.D.; Dennis M. Doody, M.D.; William B. Zipf, M.D.; John H. Ackerman, M.D.; Charles Croft, Sc.D.; Leonard Porter, M.Sc.

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THE Ohio STATE Medical Journal

(ISSN 0030-1124)

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Neal L. McCue

Ohio Medical Indemnity Mutual Corporation has designed a new plan to assure providers prompt reimbursements for their services . . . and the time to sign up is now.

The OSMA and the Auxiliary: A Synergy of Action..... 395

S. Baird, Pfahl, Jr., M.D.

The OSMA Auxiliary is not a "card and luncheon club." It's a strong and viable part of the Association, and OSMA's new President-Elect tells why.

Medical Malpractice. An Ohio Survey 397

Sidney F. Miller, M.D.

What is the climate currently like for malpractice in Ohio? An Ohio surgeon recently took a poll and details his findings here.

CME. How is it Measuring Up? 409

Ronald J. Markert, Ph.D.; John Barton, Ph.D.; Alvin Rodin, M.D.

Do physicians really change their practice behavior as a result of a CME course? Is anything really learned by the participants? Here's a fascinating look at what one group discovered about the value of CME.



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Medical
Journal
Vol. 78 No. 6, June, 1982

The OSMA and the Auxiliary: A Synergy of Action
Medical Malpractice, An Ohio Survey
CME: How Is It Measuring Up?



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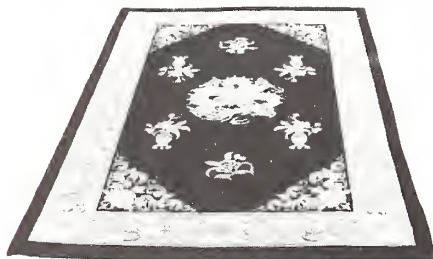
"Silverspur," caught by George D. Jacobs, M.D., of Oregon, Ohio on a late October afternoon, was one of four "Outstanding Entries" in this year's Journal Photographic Exhibit contest. Dr. Jacobs used an automatic Canon AE-1, equipped with a 1.8 lens and shot Kodachrome 25 film.

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(The OSMA Journal welcomes letters from its readers. Please address all letters to: Executive Editor, 600 S. High St., Columbus, Ohio 43215. Letters may be edited to meet space requirements.)

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The ADVANCE Plan

Editor's Note: The following letter was sent in response to Dr. Keith Kulow's letter on "Participating Agreements" which appeared in the April issue of the Ohio State Medical Journal.

Dear Dr. Kulow:

As I read my copy of the April issue of the Ohio State Medical Journal, I noted your letter to the editor regarding "Participating Agreements" and OMIM's new program.

Soon you will be receiving detailed information and an invitation to join the ADVANCE Plan, as we call our program. You will find in the literature describing the program, references to the reimbursement system. One of the modifications that we are making to the reimbursement system addresses the point you make in your letter to the editor regarding "geographical regional reimbursement areas."

With the next regular update to our maximum payable allowances, we will be eliminating the use of geographic

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When Medicine Meets Business..... 455

Leonard Rome, M.D.

Medical and business professionals team up to take a new look at an old problem.

The New Group Liability Plan 459

Carol Wright Mullinax

OSMA and PICO present a new liability plan . . . at great cost savings to you.

OSMA Annual Meeting Wrap-up 463

Pictorial highlights, a full report of proceedings and actions on resolutions are included in this special section.

C. Douglass Ford, M.D.

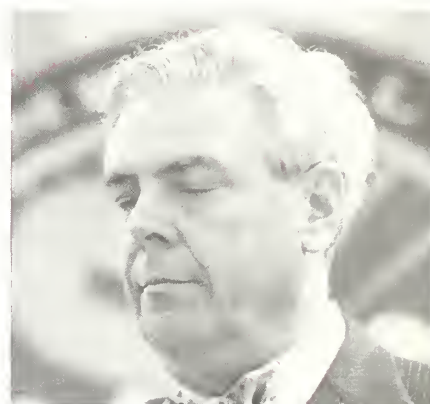
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"Ravages of Time," taken by S. Amjad Hussain, M.D., Toledo, won an Award of Merit at this year's Journal Photographic Exhibit Contest. Dr. Hussain used a Nikon camera, equipped with 35 mm lens, and shot at a speed of 125.



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(b). Each illustration should bear the figure number and the author's name on the back. When pertinent, the top of the photograph should be indicated. Do not clip, write on the back with a hard pencil, or otherwise mutilate the prints.

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(b). References should be listed in the order of their appearance in the text.

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Oscar W. Clarke, M.D. and C. Douglass Ford, M.D.

The report from the 1982 Annual Business Meeting of the American Medical Association.

Investing: Where should you put your money? 525

This special section of The Journal explores some of the different ways to invest your money today.

The Role of Laser Therapy in the Treatment of Senile Macular Degeneration: Current Status 570

Robert A. Bruce, Jr., M.D. and Frederick H. Davidorf, M.D.

In view of recent media reports promoting the role of laser therapy — especially in geriatric ophthalmology, the authors take a closer look at the facts, and make some pertinent suggestions.

Clinical and Scientific

The State of the Art of Laser Medicine 576

Leon Goldman, M.D.

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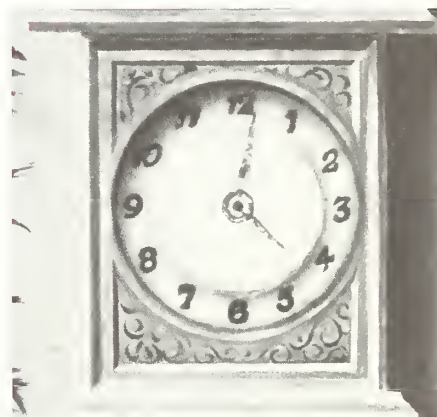
Our Cover

This month's cover was provided by free-lance artist and photographer Larry Hamill. Mr. Hamill is the photographer who provided us with the cover for our special issue on Drugs. (*The Ohio State Medical Journal*, May, 1981).

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Carol Wright Mullinax

The Journal conducts an interview with OSMA President C. Douglass Ford, M.D., on PICO's new Group Liability Plan.

Football's "Twelfth" Man 603

Robert D. Clinger

Sometimes referred to as the "twelfth man on the field," team physicians are honored each year by the OSMA. This year's "Outstanding Team Physicians" are detailed here.

Corporate health care. When hospitals mean business 609

This special section of the Journal takes a look at the latest development in health care marketing and competition. Articles have been assembled with the help of OSMA's Task Force on Competition and Marketing, and with the special assistance of OSMA staff member and Task Force liaison, Robert E. Holcomb.

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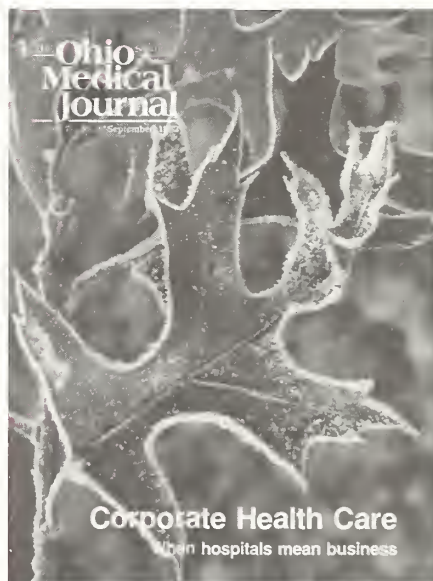
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ADVANCE intrusion

To the Editor:

If one looks behind all the fancy words used by BC/BS to describe the advantages of their Advance program, one gets the distinct impression that this is exactly what we do not need more of—the further separation of the patient from the obligation of payment to his physician. It even promotes the impression that health care is **free**, for many of the policies are part of the “bennies” obtained by union negotiations, and if the patients never see the paperwork involved. . .wow!—free medical care. This will tend to increase utilization, of

course. Think ahead, Blues. It seems nobody stops to think that all of us, including the patients, are paying for this “free” care by paying higher prices for cars, tires, televisions, fertilizer, food, etc.

By seeming to relieve the patient and physician of financial considerations, this Advance program further intrudes itself into the old-time physician-patient relationship based on the time-tested fee-for-service idea.

Sincerely,
/s/Brooks A. Mick, M.D.
Findlay, Ohio

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Carol Wright Mullinax

Profiles takes a look at Dr. Albert May who proves time and time again that he's the man to count on when there's a problem.

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For 30 years, Anthony Ruppensburg, M.D., personally headed the OSMA Committee which studied the causes behind maternal death in Ohio. Here's a personal look at this remarkable man, and his remarkable crusade.

Taking Charge 695

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Improve the cash flow in your practice . . . look into OSMA's new Bank Card Plan.

Directions/82 697

Register early for OSMA's Leadership Conference. Participants will be limited to 200, so sign up today!

The OSMA's Medical Student Section 699

Jim Augustine and Frank Papay

Here's the story of the OSMA's Medical Student Section and how it's grown.

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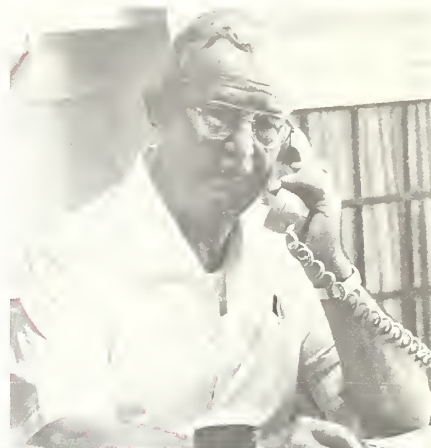
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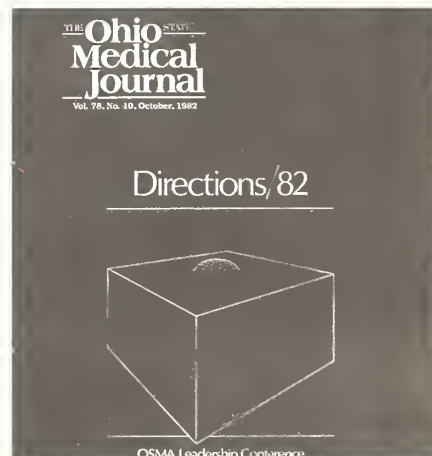
We failed to give credit in our September issue to Barbara A. Schlueter, Akron, whose picture "Gilding the Lily" captured one of four "Outstanding Entry" awards in this year's Journal Photographic Contest. This month's cover was designed by Sergai Itomlenskis, Itomik Design Studios.



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Letters ...to the editor

Severed relationship

To the Editor:

I am writing to protest the handling of the surgical bill of one of my patients by Blue Shield. The patient had a tumor at the base of his throat. I opened up the base of his neck, explored the tumor area, determined the tumor to be inoperable as it wrapped around his trachea, took a biopsy, and closed the wound. This procedure was technically difficult and my standard fee for such a difficult procedure is \$150.00. (I have described the surgery to other physicians and surgeons, all of whom indicated they would have charged at least as much. Blue Shield, however, took my billing of "neck exploration," converted it to

"biopsy," and paid only \$50.00. It is ludicrous to charge the same fee for a difficult procedure as I would charge for a routine biopsy of, say, a mole on the back. I protested the handling of this matter to Blue Shield — to no avail. My **former** patient is now convinced that I am overcharging. Our relationship has been permanently severed.

Because I have been so mistreated in this case, I will not join the Blue Shield "advance plan." What a joke!

Sincerely,

/s/ W. E. Feeman, Jr., M.D.

Bowling Green, Ohio

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Features

El Greco of Toledo 745

James G. Ravin, M.D.

The elongated figures, the bright colors, were all part of El Greco's style . . . or were they, in fact, the result of an ocular defect?

The Ohio Medical Malpractice Survey. Footprints of the Dragon..... 754

Sidney F. Miller, M.D.

Malpractice has become a nationwide problem — but this article takes a look, specifically, at how the medical malpractice dragon is leaving its mark in Ohio.

Graduate Medical Education. Who is Responsible? 463

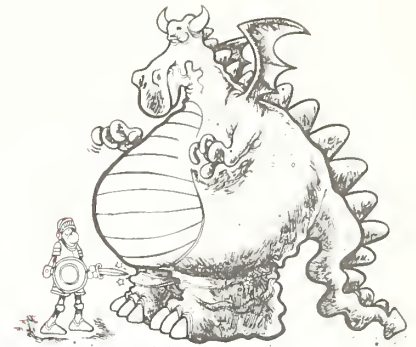
Stephen Peterson, Ph.D. and Alvin E. Rodin, M.D.

As of July, residency programs were asked to comply with a new set of general requirements. How the new requirements differ from the old, and their potential long-range effect is explained here.

OSMA Publication Readers Speak Out 781

Karen S. Edwards

The results of this spring's readership survey have been tabulated, and are discussed here.



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773

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Our Cover

"Agony in the Garden" by El Greco is one of the paintings featured in a special exhibit on El Greco at the Toledo Museum of Art. (Photograph of painting courtesy of the Toledo Museum of Art.)



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3. FREQUENCY OF ISSUE Monthly		4. NO. OF ISSUES PUBLISHED ANNUALLY 12	5. ANNUAL SUBSCRIPTION PRICE \$15
6. COMPLETE MAILING ADDRESS OF KNOWN OFFICE OF PUBLICATION (Street, City, County, State and ZIP Code) (Not printers) 600 E. State Street, Athens, Ohio 45701			
7. COMPLETE MAILING ADDRESS OF THE HEADQUARTERS OR GENERAL BUSINESS OFFICES OF THE PUBLISHERS (Not printers) 600 S. High Street, Columbus, Ohio 43215			
8. FULL NAMES AND COMPLETE MAILING ADDRESSES OF PUBLISHER, EDITOR, AND MANAGING EDITOR (This item MUST NOT be blank)			
PUBLISHER (Name and Complete Mailing Address) The Ohio State Medical Association, 600 S. High St., Columbus, Ohio 43215			
EDITOR (Name and Complete Mailing Address) Karen S. Edwards, 600 S. High St., Columbus, Ohio 43215			
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Twenty-second Maternal Mortality Report 813

OSMA's Committee on Maternal and Neonatal Health

This statistical look at maternal mortality, recorded from the fall of 1979 until May 30, 1982, is discussed by members of the Maternal Health Committee.

A Matter of Worth 817

Robert A. Dell

Hundreds of Ohio physicians are working closely with the Rehabilitation Division of the Industrial Commission to help disabled employees reassert their worth in the work force.

Health-care Costs and the American Lifestyle:

Views of the Professional..... 823

A. Kristina Burkhart, J.D., and Craig G. Burkhart, M.D.

As a physician, you are all too familiar with health care costs, and how lifestyle affects that cost. But what about your counterparts in other professions? A Toledo physician and his wife have surveyed other professionals on this subject, with some surprising results.

Attitudes toward Health: A Professional's Perspective..... 829

A. Kristina Burkhart, J.D., and Craig G. Burkhart, M.D.

Solving the Paper Chase..... 833

Karen S. Edwards

Paperwork can prove to be a problem in any organization. Here's how the OSMA solved its paper chase.

Clinical and Scientific

The Vertical Laminar Air Flow System at Mt. Carmel Medical Center — A Second Look..... 850

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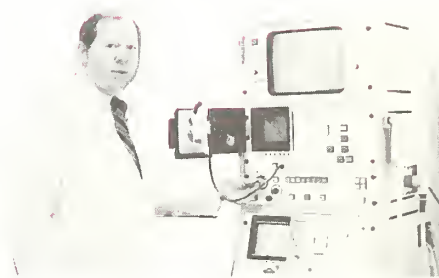
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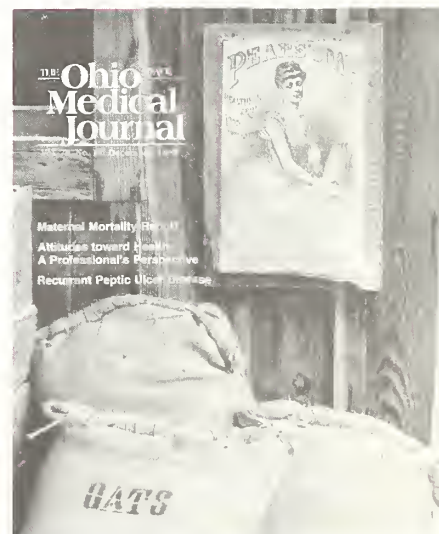
OSMA Journal Photo contest's repeat winner, Vera Kalnins, won an "Outstanding Entry" award with this picture entitled "Oats."



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• Medical authors may be interested in Emory University's Symposium and Workshop on Medical and Scientific Writing, to be held December 3-5, on the Emory campus. Write to Emory University School of Medicine, Woodruff Medical Center, 1440 Clifton Rd., N.E., Atlanta, Georgia 30322, for a free brochure.

COLLEAGUES IN THE NEWS



STANLEY BROADNAX, M.D., Cincinnati, and **EDWIN WOLIVER, M.D.**, Cincinnati, were elected to the board of trustees of the Health Planning and Resource Development Association of the Central Ohio River Valley.

WILLIAM T. COLLINS, M.D., Lima, was elected president of the American Cancer Society, Ohio Division, Inc. Dr. Collins is a pathologist and director of laboratories at Lima Memorial Hospital.

Also elected were **PAUL R. ZEIT, M.D.**, Burton, vice president, and **FRANK A. CEBUL, M.D.**, Wooster, secretary.

HERBERT DERMAN, M.D., Columbus, was elected vice president of the College of American Pathologists. Dr. Derman is director of pathology at Riverside Methodist Hospital and clinical professor of pathology at Ohio State University College of Medicine.

The following physicians were honored for maintaining a quarter-century membership in the American Academy of Family Physicians: **CHARLES FORRESTER, M.D.**, **EDWARD J. SINGER, M.D.**, **JOSEPH A. PROVENZANO, M.D.**, **MARGARET MILLER, M.D.**, and **CRAWFORD FELKER, M.D.**, all of Toledo; **EDWARD D. SCHUITMAN, M.D.**, Genoa; **DANIEL WOLFF, M.D.**, and **MICHAEL O'TOOLE, M.D.**, Maumee; **EARL J. LEVINE, M.D.**, Wellston; and **JOSEPH G. BARKEY, M.D.**, Findlay.



Paul Metzger, M.D. . . . new Medical Directors president



Sylvan Weinberg, M.D. . . . serving on Section Council, Cardiovascular Disease

JACK WARNER, M.D., Ashville, received the 1981 Central Region All School Board Award of the Ohio School Boards Association. Dr. Warner is an anesthesiology specialist and an assistant professor of anesthesiology at Ohio State University.

SYLVAN L. WEINBERG, M.D., Dayton, was selected by the American College of Cardiology to serve on the Section Council on Cardiovascular Disease.

ROBERT C. GROTZ, M.D., Richfield, was appointed chairman of the physical medicine and rehabilitation division of Edwin Shaw Hospital Rehabilitation Center.

JAMES S. HERING, M.D., Marion, is coleader of the professional division of the 1981 Marion County United Way campaign.

J. RICHARD HURT, M.D., West Jefferson, was reelected to serve a three-year term on the Columbus Technical Institute Board of Trustees.

JAMES V. KENNEDY, M.D., Mount Vernon, was appointed medical director of Country Club Center II. Dr. Kennedy is a staff physician at the Mount Vernon Developmental Center.

MARSHALL KLAUS, M.D., Cleveland, was elected voting member of the National Society to Prevent Blindness. Dr. Klaus is an associate professor of pediatrics at University Hospitals of Cleveland.

PAUL S. METZGER, M.D., Upper Arlington, vice president and chief health and medical director of Nationwide Insurance, has been installed as president of the Association of Life Insurance Medical Directors of America.

THOMAS MEANEY, M.D., Cleveland Heights, has received the Ohio State Radiological Society's Outstanding Achievement Award. Dr. Meaney is chairman of the division of radiology at the Cleveland Clinic Foundation.

The 1981 "Family Physician of the Year" award was given posthumously to **ROBERT E. REIHELD, M.D.**, Orrville, at the 31st Annual Meeting of the Ohio Academy of Family Physicians.



Letters ...to the editor

Informed consent

To the Editor:

I heartily commend Dr. Hunt for his excellent article on Informed Consent appearing in the November, 1981 issue of the *Journal*. Too many modern physicians view legal doctrines, especially in sensitive areas like informed consent, with a sense of mystery and anxiety, and wrongfully perceive the purpose of legal regulation as gratuitous encroachment upon the medical domain.

Dr. Hunt performs a valuable service as a physician writing for other physicians, in stressing that while there are no simple solutions to complex questions (in law or in medicine), the law on informed consent as well as other issues fully supports and encourages the rendering of quality, appropriate care in a humane manner.

In other words, the law merely requires what good clinical practitioners already do. Learning this important lesson should reduce physician apprehensiveness and enhance the worth of the doctor-patient relationship.

Sincerely,

/s/Marshall B. Kapp, J.D., M.P.H.
Assistant Professor
Wright State University
Dayton, Ohio

Communicating in Huron

To the Editor:

I was delighted, enchanted, and stimulated by your excellent article in the October issue — "And Now — A Word from Your Doctor."

For it brings back memories.

You may be interested in knowing that, though not in the glamour of the television screen — I have been conducting "Educational Communications" with my patients and community since 1957, when I began sending a letter on pertinent health topics with each statement that my patients received.

The letters were well received, however, I began feeling as if I were carrying on a monologue.

Consequently, in 1964, when I built a new office, I purposefully added a 1600 square foot basement for educational purposes.

Approximately every two to three months, I would carry on "classes" for an average of 55 to 65 patients. The conduct of the meeting would be as follows: A ten- or fifteen-minute presentation by me; a ten- or fifteen-minute film and/or model and/or chart presentation; followed by questions and answers. At times, the question and answer period would go on beyond an additional hour.

I suggested to the Huron County Medical Society that since "Patient Education" was an additional service that seemed to be gratefully received, we might start a patient education

program on our own local radio station.

The suggestion was unanimously endorsed by the Huron County Medical Society, the Huron County Heart Association, and the Huron County Health Department.

In July 1970, the program "Call the Doctor" (named after Dr. Thielen's already successful program) was started on our local radio station — WLKR — at Norwalk, Ohio. It's still going strong today.

Keep up the superb job.

/s/N. M. Camardese, M.D.

Chairman, Legislative Committee
Huron County Medical Society
(Norwalk, Ohio)

(The OSMA Journal welcomes letters from its readers. Please address all letters to: Executive Editor, 600 S. High St., Columbus, Ohio 43215. Letters may be edited to meet space requirements.)

CPR Guidebook Available

CPR — How to Save a Life Using Cardiopulmonary Resuscitation. By Lindsay R. Curtis, M.D.; HP Books; \$3.95.

This handy, yet comprehensive manual on CPR and other lifesaving techniques offers the lay person, as well as the health care professional, an easy reference guide to proper emergency procedures.

Copies may be ordered from: HP Books, Box 5367, Tucson, AZ. 85703.



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Designing and Building Your Own Professional Office. By Murray Schwartz, D.D.S.; *Medical Economics Books*; \$22.50.

If you've ever wanted to either design or build your own office, then this book, by a professional, could be the guide you need to see you through a maze of potential problems.

The book provides strategies for buying, building, or leasing an office, and then details the step-by-step process of construction, renovation, furnishing, equipping and decorating. It tells you how to get the right amount of space, choose an architect, evaluate floor plans, and how to ask the right question at the right time to avoid costly omissions.

The book is available from Medical Economics Books, Box 157, Florence, Ky. 41042. Add \$1.25 for handling. Payment should accompany orders.

Clinical Assisting, Vol. 7 and Supplies and Office Maintenance, Vol. 8, of Doctors' Administrative Program Series. Avis Bosshart Ziegler; *Medical Economics Books*, \$13.95.

The word is out — and just in time for this special issue — that the newest books in the Doctors' Administrative Program series, published by Medical Economics Books, are now available.

Clinical Assisting (Vol. 7) explains how to establish professional relationships with patients; how to assist with physical examinations and patient histories; how to handle treatment and ongoing therapy; and how to maintain good patient records.

Supplies and Office Maintenance (Vol. 8) details procedures for taking inventory, determining need and ordering supplies. It also explains how to maintain reusable equipment and organize and schedule office cleaning.

All pages in this series of volumes are 3-hole punched so that the book's contents can be easily divided among notebooks, specifically tailored to each assistant's assigned responsibilities.

Other volumes in the series are:
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Copies of any of the listed volumes are available from the publisher: *Medical Economics Books* (DPRL1), Florence, Ky. 41042. Please include \$1.25 for handling.

Radiation and Human Health. By John W. Gofman, M.D., Ph.D.; *Sierra Club Books*; \$29.95.

A complete look at radiation and how it affects human health is the subject of this book, written by an author who is a physician as well as a doctor of nuclear and physical chemistry.

The book covers a wide span of issues in this area — from a history of developments to arithmetic guidance, gamma radiation and Hiroshima-Nagasaki studies. Copies of the book may be ordered from: The Committee for Nuclear Responsibility, Inc., P. O. Box 11207, San Francisco, CA. 94101.

The Doctor's Tax Manual. Matthew Bender and Company; \$25.

Just in time for the 1982 tax season, *The Doctor's Tax Manual* provides a step-by-step instruction guide to your year-round tax problems. The book maps out future tax savings strategies, examines more than 2,000 deductions and credits and shows what items may trigger an audit — and why. Different organizational formats for medical practice are analyzed and discussed, with advantages and disadvantages, comparison of retirement benefits and other gains spelled out.

For a copy of the book, write to Mr. Michael Shor, c/o Matthew Bender and Co., 235 East 45th Street, New York, N.Y. 10017.

Medical and Health Annual, 1982. Edited by Ellen Bernstein; *Encyclopaedia Britannica, Inc.*; \$18.95.

Included are articles on malady-manufacturing in its various forms; the history of cigarette advertising and its campaign to lure people to take up or continue smoking; miracle healings at Lourdes, France; how drawings by emotionally ill patients can provide clues on the ways individuals deal with their anxieties; and some of the recent technological advances in neurosurgery.

Four articles — three of them by Nobel laureates — comprise a special symposium concerning the Nobel Prize of Physiology or Medicine. Three Nobel Prize winners — Francis H.C. Crick (1962), Baruch S. Blumbers (1976) and Rosalyn S. Yalow (1977) — describe the discovery process as it was for each of them and how medical science has changed as a result of their work.

Copies may be obtained from the publisher. For further information, write *Encyclopaedia Britannica*, 425 North Michigan Avenue, Chicago, Illinois 60611.

Laboratory Diagnosis and Patient Monitoring: Clinical Chemistry. Edited by Robert S. Galen, M.D.; *Medical Economics Books*; \$19.95.

As a clinical chemistry overview of the laboratory, this book takes a variety of subjects, ie, new math in the lab, turning lab values into action, hypertension and chemical analysis, and turns it into a highly readable reference book for the professional or the student.

The text is divided into three easy-to-use sections to give readers the information they want simply and quickly. Part I deals with the conceptual framework that lays the foundation for determining whether a patient is sick or well. Part II is concerned with diagnosis, and Part III with patient monitoring.

The book is available by writing: *Medical Economics Books*, Box 157, Florence, Ky. 41042. Mail orders should include \$1.25 for handling.



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STATE

RICHARD A. AYISH RESIGNS

After five years of dedicated and distinguished service, Mr. Richard A. Ayish has resigned as Associate Director of the Department of State and Federal Legislation, effective December 1, 1981. Rick has assumed the position of Senior Director of Public Affairs for Ohio Medical Indemnity Mutual Corporation.

Rick's services were invaluable to the efforts of the OMSA and he will be sorely missed. We take this opportunity to thank Rick for his contributions and to wish him well in his new position.

LEGISLATURE RECESSES - TO RECONVENE IN JANUARY

The 114th General Assembly concluded its first year of activity by passing a record \$13.5 billion budget funded with \$1.3 billion in new taxes. The budget was finally enacted in early November following 10 months of hearings and two interim budgets. The first year of the biennium was almost totally dominated by the budget process, as legislators struggled to reconcile the state's shrinking revenue base with the demand for increased funding needed to maintain the state's basic services. Rising inflation, increasing unemployment, and the uncertain effect of President Reagan's "new federalism" on the state combined to make the legislators' task of complying with the constitutional requirement of a balanced budget arduous to say the least.

It was apparent early on that irreconcilable differences existed between the House and Senate and a four-month interim budget reflecting across-the-board cuts was adopted. Governor Rhodes then stepped forward and proposed a series of temporary tax increases, an idea which was quickly rejected. Talk quickly turned to enacting permanent tax increases and the debate centered around which ones and how high. After another interim budget, a package was finally put together which attracted enough votes in the House and Senate to assure passage and it was quickly signed by the Governor.

Despite the combination of substantial cuts and \$1.3 billion in new taxes, the state's budget may yet prove to be inadequate. If Ohio's and the nation's economy continue to be sluggish (state revenues were \$88 million below projections for November), the Legislature will have to return next year and begin the battle with the budget anew.

The 1982-1983 budget did contain a number of provisions important to organized medicine, including a 1981 OSMA House of Delegates mandate. The major health provisions of the new state budget are as follows:

Premarital serology testing: Pursuant to the 1981 resolution of the OSMA House of Delegates, the OSMA worked with Rep. Fred Deering (D-Monroeville) to repeal the mandatory premarital serology testing for syphilis.

Health System Agencies: With the support of the OSMA, the Department of Health, and other groups, Rep. John Wargo (D-Lisbon) was successful in amending the budget to eliminate reference to the state's health system agencies. Individual HSAs will continue to operate until contracts with the federal Department of Health and Human Services expire late next spring. At that time, health planning will be centralized in the Ohio Department of Health.

State Medical Board: At the urging of the State Medical Board, the General Assembly increased physician license renewal fees from \$50 triennially to \$100 biennially, beginning at the completion of the current renewal period, January, 1983. The OSMA was successful in amending the budget bill to eliminate the necessity of physicians mailing their CME log books to the board for license re-registration. Instead, physicians will be able to certify by signature on the license renewal application that the requisite hours of CME have been completed. Physicians should retain CME documentation, however, as the Medical Board retains authority to audit CME records.

Public Health Standards: The legislature moved for the first time to establish statewide "minimum standards" and "optimum achievable standards" for boards of health and local health departments. These standards are to be promulgated by the Public Health Council within three years following recommendations by a task force to be appointed by the Council. State subsidies to local health boards and departments will be contingent upon meeting the standards.

Medicaid: The General Assembly enacted several problematic revisions of the state Medicaid program in an attempt to cut costs. Medicaid recipients will be required to pay a 10 percent copayment for medical services, including physician services and outpatient/emergency services if approved by the federal Department of Health and Human Services. In addition, reimbursement will be made for only up to 30 days of inpatient hospital care.

A pilot study was created requiring inpatient services be provided at the "lowest cost" hospital within a 15-mile radius of the recipient's home. The OMSA believes this project is ill-conceived and unworkable.

The OSMA was successful in creating a six-member legislative committee to study the levels and timeliness of physician reimbursement under Medicaid.

Finally, the Department of Public Welfare is directed to engage in several studies concerning cost containment: (1) alternative reimbursement methods for outpatient services; (2) prospective reimbursement for hospital inpatient services; (3) mandatory generic drug substitution; (4) exemption of copayment when generic drugs are substituted; (5) limiting recipients to a single source for drugs; and (6) contracting with an underwriter for the entire Medicaid program. The results of these studies are to be reported to the legislature.

In addition, the OSMA was successful in fulfilling another House of Delegates mandate when the House passed by an 82-8 vote Senate Bill 98, the OSMA's determination of death legislation. The bill, having passed the Senate earlier in the year, is now awaiting the Governor's signature.

SELECTED PENDING STATE LEGISLATION

HOUSE BILL 317 — (J. Thompson, D-Cleveland) — MEDICAL BOARD

HB 317 is a redraft of last session's SB 368. The bill is structured to increase the funding and staffing of the Board through an increase in fees, to grant the Board investigative subpoena power similar to some other state agencies, to authorize emergency license suspensions pursuant to clear and convincing evidence of a danger to the public, to expedite appeals of Board orders, and to protect the confidentiality of patient records and Board records. HB 317 passed the House, 72-22, and has been assigned to the Senate Health and Human Resources Committee.

HOUSE BILL 173 — (J. Thompson, D-Cleveland) — HOSPITAL LICENSURE

HB 173 is a redraft of HB 753, the Hospital Licensure Bill introduced by Rep. Thompson last session. HB 753 passed the House last year and was assigned to the Senate Finance Committee, in which no vote was taken. HB 173 establishes an Ohio hospital licensure law incorporating federal Medicare standards. JCAH accreditation or Medicare certification would give rise to presumption of compliance with licensure standards. The bill limits hospital admitting privileges to physicians and dentists, with coadmission privileges recognized for podiatrists. HB 173 is being heard in the House Health and Retirement Committee.

HOUSE BILL 469 — (Mahnic, D-Cleveland) — C.O.N.

HB 469 is a reintroduction of last session's SB 291. The bill modifies Ohio's certificate-of-need law pursuant to federal statutes. The OSMA was successful in amending the bill to repeal state certificate-of-need requirements if either federal funding is eliminated or the federal law is repealed. The bill has passed the House and been referred to the Senate Health and Human Resources Committee.

HOUSE BILL 664 — (Hinig, D-New Philadelphia) JOINT UNDERWRITING ASSOCIATION

HB 664 authorizes the Ohio Joint Underwriting Authority to reinsure all of its insurance liabilities through a private insurance company chosen by competitive bidding. The bill directs the return of surplus JUA funds, and SRF funds, remaining after the 1980 return, to physicians and hospitals that have contributed to the funds. The bill has been referred to the House Insurance Committee.

SENATE BILL 159 — (Kasich, R-Westerville) — SPORTS PHYSICIAN IMMUNITY

SB 159 provides immunity from civil liability to physicians and others who provide emergency care to participants in a school athletic event, unless the treatment constitutes willful or wanton misconduct. The bill passed the Senate and House and became effective October 20, 1981.

SENATE BILL 336 — (Cox, D-Barberton) — ALCOHOLISM COVERAGE SUNSET EXTENSION

SB 336 extends mandatory insurance coverage for mental health and alcoholism, as enacted by SB 90 of the 112th General Assembly. SB 336 eliminates the sunset clause in SB 90 and proposes extensive revisions in the insurance coverage mandates. The bill has been referred to the Senate Elections, Financial Institutions and Insurance Committee.

SENATE BILL 365 — (Van Meter, R-Ashland) — MENTAL OUTPATIENT COVERAGE FOR ALCOHOLISM

SB 365 requires that certain health insurance contracts offer outpatient coverage for mental and emotional disorders, and outpatient, inpatient and residential care coverage for alcoholism treatment. The bill, in effect, removes the sunset clause from SB 90 of the 112th General Assembly. The bill is being heard in the Senate Elections, Financial Institutions, and Insurance Committee.

SENATE BILL 204 — (Skall, R-South Euclid) — STATE OFFICER IMMUNITY

SB 204 would entitle individuals who render "medical, dental, psychiatric, or psychological services to wards of the state" as an employee of or pursuant to personal services contract with an agency of the state, to representation, immunity, and indemnification in civil actions arising from the delivery of such services. Drafted by the Department of Rehabilitation and Corrections at the request of the OSMA, the bill has passed the Senate and is in the House Judiciary and Criminal Justice Committee.

HOUSE BILL 442 — (Carney, D-Boardman) — PHYSIATRIST PHYSICAL THERAPY LICENSURE

HB 442 permits a physiatrist to register with the Ohio Occupational Therapy and Physical Therapy Board for licensure as a physical therapist without taking the state's physical therapy examination or paying a license fee. HB 442 has been referred to the House Health and Retirement Committee, and is opposed by the Physical Therapy Board.

Healthy People

A Report from the Council on Scientific Affairs

Editor's Note: This report has been edited to meet Journal space requirements. For a complete copy of this report, please write to the OSMA, 600 S. High St., Columbus, OH 43215.

Substitute Resolution 98, which was adopted at the 1979 Interim Meeting, commended the Surgeon General for his leadership in health promotion and disease prevention and called on the AMA Board of Trustees to "review the Surgeon General's Report on Health Promotion and Disease Prevention and refer the recommendations to the appropriate AMA units for their review and any indicated action."

In response to Substitute Resolution 98, Board of Trustees Report CC (A-80) referred the matter of recommendations for appropriate AMA action to the Council on Scientific Affairs with the request that "it prepare an appropriate long-range plan that would coordinate and expand continued AMA activities in the area of health promotion and disease prevention." It was further asked "to respond to this request on a timely basis so that the House of Delegates can be properly informed of developments in this area." The AMA Council on Scientific Affairs has reviewed the Surgeon General's Report on Health Promotion and Disease Prevention entitled "Healthy People," and reports its agreement with the assessment that further improvement of mortality statistics in the U.S. can best be accomplished by attacking those unhealthy behavior or lifestyle practices that contribute to such chronic illnesses as cardiovascular disease and cancer.

Although the AMA has been active in health promotion and disease prevention, a greater effort in this arena is required if it is to maintain its position of leadership and actively support the initiative of the Surgeon General.

The Council believes that the role of the AMA should be to report on the state of the art of those techniques proven effective in getting people to reduce or to stop smoking cigarettes, to eat a more sensible diet, and to adhere to appropriate anti-hypertensive drug regimens. These are areas where other substantive scientific issues are of secondary importance to the methodology for achieving behavior change.

During each of the next five years there will be at least one conference, one workshop, and one continuing medical education course dedicated to this area. A different aspect of health promotion will be emphasized each year, focusing on a different substantive issue and a different methodology of behavioral change. The following program has been suggested by the Council.

Health Promotion Project

Conference Topics:

- Factors Determining Drug Adherence in Hypertensive Management
- Nutrition and Physical Activity in the Maintenance of Health
- Health Effects of Trace Chemicals in Water Supplies
- Carcinogens in the Work Place
- The Prevention of Hypertension

Workshop Topics:

- Physical Exercise Programs in the Work Place
- Reduction in Incidence of Low Birth Weight Neonates
- Relaxation Techniques - Stress Control
- Behavioral Modification in Weight Reduction
- Group Dynamics in Weight Control, Smoking Cessation or Alcohol Withdrawal

CME Courses:

- Reducing the Risk of Alcoholism and Drug or Tobacco Dependence
- Management of Insomnia: Therapeutic Alternatives
- Obesity Control - Making Sense from the Diet Maze
- Immunization Update
- Management of Hyperlipidemia - Drugs Versus Diet
- The cost of the proposed conferences can be defrayed through registration fees and the cost of publication can be offset by later sales of the publication, whether by the AMA or an outside publisher.

As part of the program, the AMA Department of Health Education will work through the AMA federation to bring information to state and county medical societies that will assist them in enhancing physicians' skills in patient and health education, and in developing community services for modifying undesirable behavior.

The AMA Auxiliary has engaged in a promotional campaign for the second consecutive year entitled "Shape Up for Life." This has been actively

Continued on page 38

NEWS

a compilation of the latest developments, reports and products of interest to physicians.

**edited by
Karen S. Edwards**

Medical-samples-by-mail

A new publication-cum-service is providing a new, and presumably a more cost-effective way, for pharmaceutical companies to distribute medical samples to physicians.

Therapeutic Sampler is the name of a new publication which will be issued regularly, beginning this month, to over 70,000 physicians, nationally. Recipients will simply leaf through the journal's pages, decide which samples they want, and mark them on a business reply card attached to the publication. The samples will arrive without further effort.

The idea is to save both the high costs of gasoline and detail people without limiting the traditional supply of samples which pharmaceutical companies provide physicians for a variety of uses: stat dosing, trial regimens, indigent needs, and so on.

Physicians interested in receiving a copy can write to the publisher, Mr. W. R. Maher, Medical Publications, Inc., 210 Forest Avenue, Glen Ridge, New Jersey 07033.

Beverly Hills Diet deemed ineffective and dangerous

Judy Mazel's *The Beverly Hills Diet* "is the latest and perhaps the worst, entry in the diet-fad derby," report two Maryland physicians in a recent issue of the *Journal of the American Medical Association*. Gabe B. Mirkin, M.D., and Ronald N. Shore, M.D., claim the diet preaches "nutritional nonsense," propagating medical inaccuracies that could present hazards — some possibly life-threatening — to its devotees.

The Beverly Hills Diet is based on three erroneous ideas, according to Mirkin and Shore. The first is that undigested food accumulates and becomes fat, while digested food cannot cause weight gain.

Actually, the physicians point out, undigested food is not absorbed from the intestines; it is excreted, supplying no calories whatever. Instead, it is digested food that has the potential for adding to body weight.

The Beverly Hills Diet also claims that most enzymes cannot work together, often cancelling each other out in the digestive tract.

In fact, enzymes that break down food prior to absorption must be able to work together. Because virtually all foods contain combinations of carbohydrates, protein and fats, the enzymes that break them down have to work in tandem, the physicians say.

The diet's third tenet is that fruit enzymes make hard-to-digest foods less fattening.

Not so, according to Mirkin and Shore. The enzymes in fruit are proteins, and all proteins are broken down in the stomach and intestines. They do nothing to break down other foods during digestion.

The Beverly Hills Diet begins with an 11-day regimen of eating nothing but fruit. This can result in severe diarrhea, the physicians warn, with potentially life-threatening consequences such as shock from fluid loss and cardiac arrhythmia due to potassium depletion.

Because the diet does not satisfy the body's protein needs for at least the first six weeks, rapid loss of scalp hair is also a possible side effect.

Plaster casts not always the best cure

Immobilizing joints in plaster casts starves the tissues and can lead to joint destruction, says a Toronto orthopedic surgeon in a recent issue of the *Journal of the American Medical Association*.

Robert B. Salter, M.D., of the University of Toronto, thinks orthopedic surgeons who "make a fetish out of applying plaster casts" should instead look to the use of motion to heal injured or diseased joints.

Salter has found that continuous passive motion (CPM) can have a dramatic effect on joint healing. In CPM, the joint is moved by a mechanical device through a pre-set range of motion during a specified

time period; for example, one cycle every 40 seconds. This movement allows a continuous flow of synovial fluid through the joint. According to Salter, synovial fluid is the only source of nutrition available to the joint cartilage, which lacks blood vessels and nerves.

Salter speculates that elderly, arthritic individuals in rocking chairs may unwittingly be using that continuous, regular motion as a form of CPM to ease pain and stiffness in their joints. As further justification for CPM, Salter points out that the lowest incidence of degenerative arthritis in a joint occurs in those joints connecting the ribs with the spine, which move continuously with every breath.



Communication made easier for handicapped

Physically handicapped individuals are now able to communicate more effectively, thanks to a product entitled "Help-Mate," marketed by the Gulf and Western Research and Development Group.

Help-Mate uses the latest microcomputer technology to help quadriplegics and those with cerebral palsy (for example) to communicate, using a special typewriter. Activated by the nod of a head, the blowing of a puff of air, or the use of a mouth switch, Help-Mate permits the handicapped to select letters and

numbers on the unit's television screen. After writing, editing or correcting the copy, the user can then direct the machine to print out the text on a computer printer.

Costs have been kept low by using mass-produced modules which make the system easy to set up and service. Only a standard TV set is needed. The Help-Mate itself is complete, ready to plug in and run.

For further information, contact Gulf and Western Applied Science Laboratories, 335 Bear Hill Rd., Waltham, Mass. 02154.

AMA makes staff changes . . .

The American Medical Association (AMA) has recently made some staff and organizational changes which AMA Executive Vice President, James H. Sammons, M.D., claims "is another step in strengthening our organizational capabilities for the work and challenges that lie before us for the long term."

The AMA has consolidated its programs into two major areas: public, scientific and health service policy activities; and business, publishing and management services. Whalen M. Strobhar was named Deputy Executive Vice President for Public, Scientific and Health Service Policy, and Thomas F. Hannon was named Deputy Executive Vice President for Corporate, Publishing and Management Services.

C. H. William Ruhe, M.D., will retire from the position of Senior Vice President for Scientific Activities effective February 1, 1982, and William R. Barclay, M.D., will retire as editor of the *Journal of the American Medical Association (JAMA)*, effective December 1981. Replacing Dr. Barclay as editor of *JAMA* will be George D. Lundberg, M.D., chairman of the Department of Pathology, University of California - Davis. Dr. Lundberg has served as a member of *JAMA's* editorial board since 1973.

Scurvy's reappearance linked to diet

A recurrence of scurvy, a disease thought to have been wiped out in the United States, prompted New York physician Victor Herbert, M.D., J.D., to question the methods physicians use to determine the dietary habits of their homebound patients.

In a letter to the *Journal of the American Medical Association*, Herbert cites the case of a man exhibiting symptoms of scurvy, a disease caused by severe vitamin C deficiency due to poor diet or alcoholism. Hospital staff members noted only that the patient was not an alcoholic and "ate well" before asking Herbert to examine him.

Through questioning Herbert discovered that the man, jobless and without a working refrigerator, subsisted on coffee and one daily meal of rice and canned sardines in tomato sauce. The vitamin C in the tomato

sauce should have been sufficient to prevent the development of scurvy. On further investigation, however, Herbert found that the food mixture was boiled, effectively destroying most of the vitamin C content.

"This case of scurvy illustrates both the basics of sound nutrition and the value of an adequate dietary history," Herbert writes. He urges physicians to establish an accurate history, including the methods by which food is prepared, before making any firm diagnosis.

The advice is particularly appropriate for physicians who care for homebound elderly, disabled or mentally ill patients; alcoholic patients; and patients whose economic circumstances render them unable to purchase or store fresh produce regularly.

Meetings

Spectrum of Developmental Disabilities: Birth through Infancy.

March 15-17; Turner Auditorium, Baltimore, Maryland. This annual course will focus upon the early identification, evaluation, treatment and research issues during the first two years of life. Guest speakers include T. Berry Brazelton, William B. Carey. Registration fee, \$225. For further information, contact: Program Coordinator, Turner 22, 720 Rutland Avenue, Baltimore, Md. 21205, (301) 955-6046.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunichism, 10 to 40 mg; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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New in practice? Here are some things you'll want to know before

Setting Up Shop

By Clifton R. Veach

Establishing a new practice, regardless of size, must be carefully planned from the outset to avoid economic and management control problems that could very well have been foreseen with proper planning. It is highly recommended that anyone venturing into their own business seek expertise both in the legal aspects and the financial areas of independent business. A qualified attorney, who specializes in private enterprise, can help you avoid many of the legal complications of starting out that could be very costly at a later date. An accountant, working closely with your

up, including legal registrations, leases, insurance liabilities, etc.

(2) Financial - includes all accounting services, fee structures, bookkeeping systems, cost control systems, banking, etc.

(3) Office - includes all the physical aspects of doing business: Office space, phones, furniture, medical equipment, supplies, employees, and all miscellaneous services necessary to operation of the business.

(4) Professional - includes all association contacts, hospital privileges, media announcements, address changes, etc.

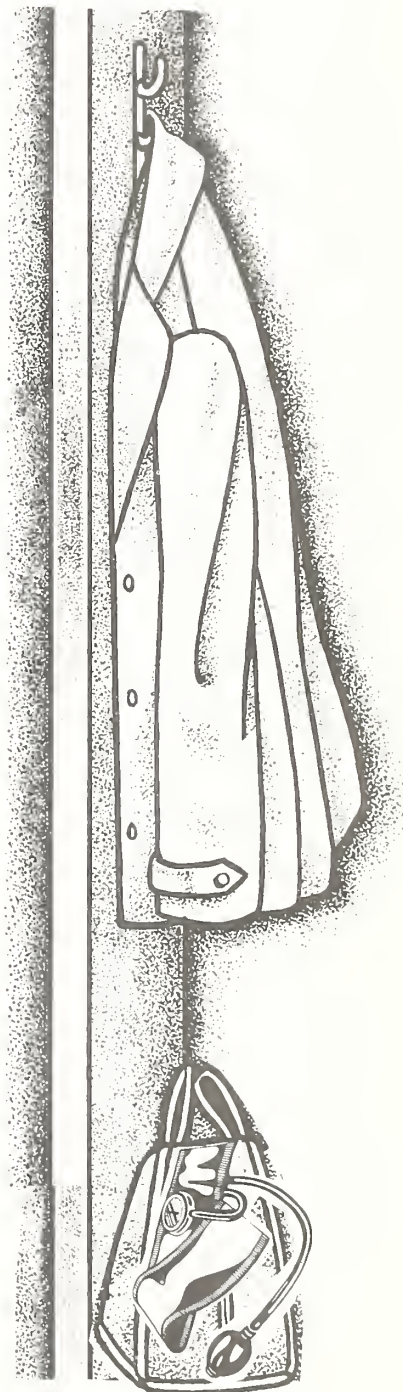
"It is highly recommended that anyone venturing into their own business seek expertise in both the legal aspects and the financial areas of independent business."

attorney, can help you decide the proper format for your business. Your accountant is the person best versed on current and future tax advantages of closely held businesses. He can also give counsel on banking and bookkeeping systems, insurance coverages, and medical insurance processing to control your cash flow.

The main elements of the business can be separated into four main categories for clarity:

(1) Legal - covers all aspects of set-

The legal and financial aspects, as well as the professional aspects, are processes which require direct attention of the proprietor, regardless of the aid of an attorney or accountant. These are areas of business which are molded to the individual or group desires and closely related to the future plans of each. The office area of setting up a practice is one area where authority can be delegated and you can draw on the prior art of existing businesses to aid you.





"If you do not take the time to do it right the first time, when are you going to find the time to correct the situation?"

The "office" aspect to the business is one area where authority should be delegated to keep track of the myriad of trivial items which can upset the smooth flow of business. After selecting the appropriate location for the office and negotiating a satisfactory lease agreement, the considerations turn to the physical operation of the business and what is necessary to accomplish this.

(A) Decorating the office - painting, papering, designating work areas, selecting furniture, etc.

(B) Medical and office equipment: Both medical and general office equipment represent a large capital expenditure and should be selected with care. Future expectations should be taken into consideration for larger capacity equipment.

NOTE: When considering equipment for business use, it is wise to consult your accountant for lease versus purchase advice which could save you tax dollars.

(C) Probably the most significantly important duty as a business manager

is the selection of qualified, conscientious employees. Time taken to properly screen employees is well spent, and will save a great deal of aggravation caused by sudden terminations. Special attention should be given potential employees with "control situation" backgrounds. These are people who work well without direct supervision and have a tendency to plan ahead to avoid problems.

NOTE: There are agencies available which specialize in the placement of medical personnel. They are useful in the preliminary screening process of employees, but keep in mind that they have a vested interest in the placement of any individual sent to you.

(D) Filing systems must be established for record keeping.

(E) Systems must be designed for proper patient flow and drug dispensing.

(F) The office must be well equipped with standard office supplies, from pens and pencils to receipt books and Scotch tape.

(G) Procedure must be established for the collection of receivables. This is of utmost importance to maintain proper cash flow.

(H) Office hours must be established.

(I) Janitorial and laundry service should be considered.

(J) Will your lab work be done in-house or sent out. Contact should be made with laboratories to compare cost factors of both.

(K) Office uniforms must be purchased.

By no means is the above a complete list of points to cover when establishing a new business, but rather an outline to illustrate the vast number of details involved. As with the legal and financial aspects, there are businesses which specialize in setting up new practices, purchasing supplies and equipment, and also complete practice management services. The money spent for expert advice is well spent, and far less expensive than paying for mistakes made this year in the middle of next year, when your time should be devoted to producing revenues for a growing practice.

With all the hard work and careful attention to a multitude of details, there is a great deal of pride and sense of accomplishment when the tasks are finished and you are ready to open the doors for business. That special attention to detail and the time taken for problem preventive planning is what it takes to insure that your sense of accomplishment does not turn to disillusionment in the face of problems which could have been prevented. If you do not take time to do it right the first time, when are you going to find the time to correct the situation? A carefully planned and efficiently operated business is not only a credit to the proprietor, but allows him the time necessary to enjoy the fruits of his labor. **OSMA**

Clifton R. Veach is the General Manager of CONSOLIDATED PROFESSIONAL SERVICES, INC., Columbus, Ohio.

Cooperative buying:

New armament in the cost-cutting war

Recently a trend in medical/clinical cost cutting has surfaced in the Columbus area. Within a few short months, an organization known as Consolidated Professional Services (CPS) has influenced the buying habits of many small to medium-sized independent clinics, laboratories and private practices. CPS is operating on the cooperative buying principle. Establishing a membership purchasing group enables CPS to buy clinical and laboratory supplies in large quantities and distribute to independent medical practices, clinics and laboratories, below current market prices. Ms. Jo Neiman Zappin, CPS Membership Coordinator, explains that service to the client is not limited to the dollars saved by the consumer facility, but eliminates hours spent monitoring fluctuating prices and product quality, as well as reducing the need to write multiple checks each month. General Manager, Clifton R. Veach adds, "Inflation and rising prices are a reality, but with more efficient use of the resources available to our consumer group as a whole, we can substantially minimize the financial effects on the individual practice or facility."

— C.R. Veach

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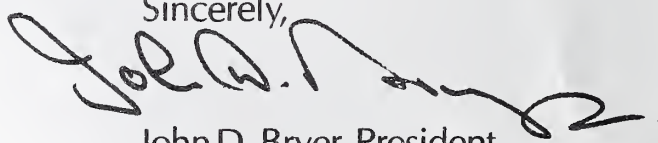
- RUFEN®** OFFERS A \$1.50 REBATE DIRECT TO YOUR PATIENTS ON EVERY BOTTLE OF 100 TABLETS OF RUFEN 400 MG.
- RUFEN** COSTS YOUR PATIENTS LESS TO BEGIN WITH.
- RUFEN** CONTRIBUTES 25¢ PER REBATE TO ARTHRITIS RESEARCH.
- RUFEN** IS NOT A GENERIC... BOOTS IBUPROFEN IS THE ORIGINAL.
- RUFEN** (IBUPROFEN) IS BIOEQUIVALENT TO MOTRIN® (IBUPROFEN).*

I hope we've given you several good reasons to remember RUFEN the next time you prescribe ibuprofen.

If we haven't, or if you'd like to know more about Boots Pharmaceuticals or this program, please don't hesitate to drop me a line. Or call us directly at our toll-free number: (800) 551-8119. Louisiana residents, call (800) 282-8671.

To ensure that your patients receive the benefits of the Rufen program, be sure to specify "D.A.W.," "No Sub," or "Medically Necessary," as required by the laws of your state.

Sincerely,



John D. Bryer, President
Boots Pharmaceuticals, Inc.



Boots Pharmaceuticals, Inc.
6540 LINE AVENUE, SHREVEPORT, LOUISIANA 71106

Pioneers in medicine for the family

RUFEN® (ibuprofen/Boots)

(For full prescribing information, see package brochure)

RUFEN® Tablets
(ibuprofen)

INDICATIONS AND USAGE: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in the long-term management of these diseases. Safety and effectiveness have not been established for Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain.

CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see WARNINGS).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration and gastrointestinal bleeding can end fatally however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease and only after consulting the ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: Coumarin-type anticoagulants. The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin. Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS

Incidence greater than 1%

Gastrointestinal: The most frequent adverse reaction is gastrointestinal (4% to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme. **Special Senses:** amblyopia (see PRECAUTIONS). **Hematologic:** leukopenia, decreased hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities. **Dermatologic:** alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** hemolytic anemia, thrombocytopenia, granulocytopenia bleeding episodes. **Allergic:** fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** gynecomastia, hypoglycemia. **Cardiovascular:** arrhythmias (Sinus tachycardia, bradycardia, and palpitations). **Renal:** decreased creatinine clearance, polyuria, azotemia.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

DOSAGE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flareups of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain. Do not exceed 2,400 mg per day.

CAUTION: Federal law prohibits dispensing without prescription.

Boots Pharmaceuticals, Inc.
Shreveport, Louisiana 71106

The 1982

Ohio State Medical Journal

Photographic Exhibit

The Ohio State Medical Journal is sponsoring its fifth annual photographic exhibit and competition. The 1982 competition is open to both physicians and spouses. Persons submitting winning entries will receive awards at the 1982 Annual Meeting, Dayton, where the entries will be displayed.

Photographs may be entered in two divisions: Black and White, and Color. Each division has two categories: General and Scientific.

Entries must be in print form (8" x 10" or 11" x 14") in size) and mounted on print board, or otherwise for ease of display on a peg board. Photographs placed under glass will not be accepted. All entries submitted must be previously unpublished, and right to publish the photograph must be given to the Journal at the time the photograph is entered in the exhibit.

An OSMA member or spouse may submit as many entries as he/she wishes. Each photo must be accompanied by an entry form and a \$10.00 entry fee. If mailed, please be certain photograph is securely wrapped to avoid possible damage.



ENTRY FORM

Name _____
If Nonmember, Spouse's Name _____
Street _____
City _____ State _____
County _____ Zip _____
Telephone _____

Information about photograph: (provide as much as possible)

Camera _____ Lens _____
Speed _____ Aperture _____
Subject _____ Film Type _____
Date _____ Time of Day _____
Title _____

Division: ☐ B & W ☐ Color
Category: ☐ General ☐ Scientific
Processing/Printing:
☐ Professional ☐ Self

Mail or hand carry the photograph, entry form and \$10 entry fee (make checks payable to The Ohio State Medical Journal) to: The Ohio State Medical Journal Photographic Exhibit, 600 S. High Street, Columbus, Ohio 43215. All entries must be received no later than March 26, 1982.

I give the *Journal* publication rights to this photograph. I certify that this photograph has not been published previously and that I will not submit it for publication elsewhere pending the judging of the photographic exhibit. Also, I certify that any person(s) pictured have given me authorization to allow publication of his/her photograph. I also understand that if my photograph is selected for a Journal cover, it may be cropped to meet printing specifications.

Signature _____

Streamlining

Your Office

By Linda N. Jesseph

A doctor's office is a twofold operation. Primarily, the office is established to fulfill the medical needs of the doctor's patients. Its secondary, and often most time-consuming purpose, is that of a business office. The number of papers making their way through the office often can end in a congested mess, defeating both the medical and business intent of the operation.

On the medical side of the paperwork are requests and communications from referring physicians, laboratory data, patient consultation notes, and medical supply inventory and orders. A good traffic pattern for the paper is mandatory. One way to significantly cut down on the congestion and filing problems associated with this amount of paper flow is to look carefully at the duplication of forms and reports that deal directly with the medical aspect of the office. A duplication of a patient record in two different places usually is unnecessary. It takes up space and time to file and retrieve it. Having an efficient and observing secretary will be your best ally in this war of paperwork. She will know what mail is really vital to you, and what can be readily dispensed and circularly filed. Naturally, there will be publications and periodicals that you will wish to

Try to get your routine established early so some designated time is set aside as "free" office time each week. This will be when you're able to catch up

...

read and maintain in a library for reference purposes, so these need to be identified. You will receive a mountain of materials from drug company representatives; some will be pertinent and most will not. Try to get your routine established early so that some designated time is set aside as "free" office time each week. This will be when you are able to catch up on dictation of reports and communications with referring

physicians and hospital medical records, reading materials and time when a representative you are interested in talking with can schedule a convenient time to discuss his new product.

Many physicians dealing in a narrow specialty field will be readily knowledgeable about a new drug or treatment method that will help his specific type of patient. Likewise, there will be those specialties with a broader range of patient diagnoses. Filing systems are available to help you locate a certain primary or secondary diagnosis in your patients which a new drug or treatment may benefit. Usually, a doctor has too many patients to recall all those with certain diagnoses, so it is helpful to have a cross-reference of some sort to which you can refer from time to time.

Be sure to set up your patient files with a dated system. This system will allow you to readily identify an old, inactive patient file and to retire it to storage until such time as the patient should reactivate. This will free up much needed space for new patients and will alleviate the time factor used in sorting through inactive files mixed in with currently active records. In addition, the dated system will help you inform your patients that it is time for a follow-up or checkup visit. This

will aid you and your patients in maintaining a better health record.

The second function of a physician's office is the "business" aspect. With today's necessity of insurance, Medicare Workers' Compensation and other forms that must be processed on a patient, complexity is the rule rather than the exception. The method most conducive to handling what can rapidly grow into an uncontrollable situation is to STAY ORGANIZED.

First of all identify the patient as either a one-time consultation, a returning patient for follow-up treatments or checkups, or a routine patient whom you might see once or twice a year. Taking the most active-type patient first (the one often returning for treatment or checkups), let his visits compile into several before you submit an insurance form. This will not only help you, but will also aid the insurance company and the patient.

The only exception to this procedure is the patient who is requested to pay at the time of the visit for services rendered. He or she may need to be reimbursed on a speedier basis for their expenditures, and it may be more cost effective to allow this patient to bypass payment at time of visit in lieu of compiling his visits on an insurance form for a one-time payment to you **directly** from the insurance company.

This brings up another business aspect of the office and that is insurance payments. It is advisable that every insurance transaction be made with payment sent directly to you, the provider. Too often funds are sent to the patient, then promptly spent by the patient, and the doctor never receives remuneration for his services. This will happen especially on a one-time consultation visit, where the patient will never have to face you again - owing you money. Protect yourself and operate your practice as a

business — assure that you will receive payment for your time and services.

Bookkeeping has become an art in the medical field. Entire companies exist, offering diverse services in every capacity to serve the physician and his practice. They will handle everything from billing to receiving payment, to maintaining a diagnoses reference file,

To summarize in one succinct word — ORGANIZE. Think through all your procedures from ordering lab tests to accepting a new patient.

investing profit funds and managing your affairs until your retirement. Only you can decide what services you could use from an outside source and how much control you wish to relinquish to someone else.

In-house methods have proven the test of time both from a financial aspect and a practical hands-on type of management. Financially, if your system is well organized and tailored to fit your specific needs, little time and effort will be wasted in producing your monthly billing and recording of your monthly income. This is the basic operation of your finances. We highly suggest the incorporation of an adequate and well-informed financial management firm to assist you in coordinating your income and expenses to allow for investment of excess funds into areas that will serve your long-term as well as short-term goals.

To summarize in one succinct word — ORGANIZE. Think through all your procedures from ordering lab tests, to filling out insurance forms, to accepting a new patient. Cut the fat off redundant paperwork and steps in your traffic pattern. To assure yourself of organization, hire personnel who are organized, and remember that usually you will get what you are willing to pay for, so don't hold back on a salary that may eventually save you money and time. **OSMA**

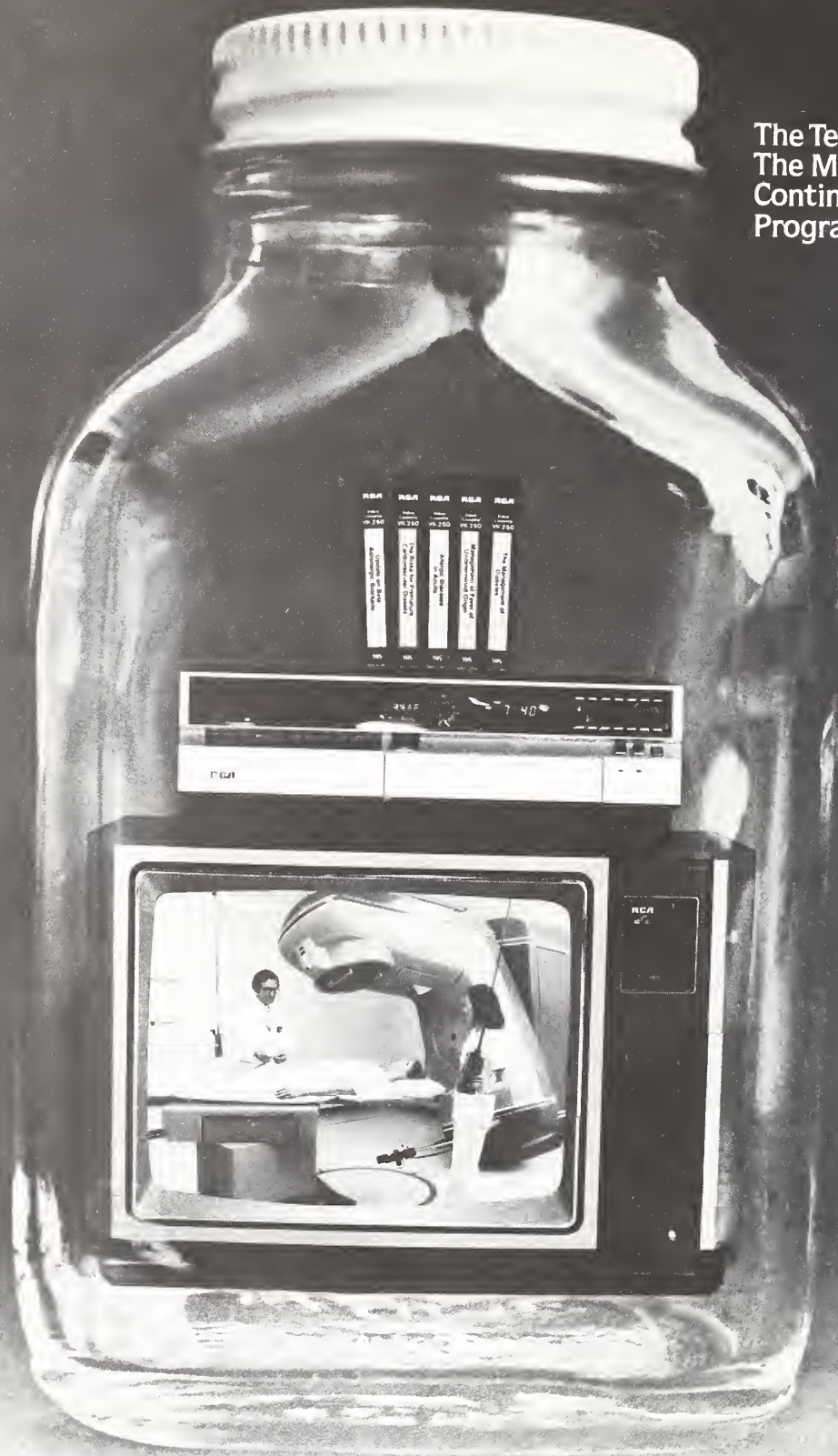
Linda Jesseph is a founding member of OFFICE ORGANIZERS. OFFICE ORGANIZERS is located in Columbus, Ohio and was founded to help facilitate the creation and organization of an efficiently run office.

ANSWERS TO ADRENAL CROSSWORD ON PAGE 60.

ACROSS: 1. Aldosterone, 5. Twenty one, 10. Tuberculosis, 12. Gee, 13. Sperm, 16. IRS, 18. Dose, 20. IV, 21. Pigmentation, 22. Mop, 23. Nash, 24. Ph, 25. Twig, 27. AIC, 29. Pupil, 31. Elevated, 33. Low, 34. Toss, 35. Salt, 37. Slow, 39. Sis, 40. Before, 41. Sun, 42. Dunce, 45. BUN, 46. Shock, 49. Keto, 53. Uses, 54. Cholesterol, 55. High, 57. RIA, 60. Growth, 65. Obesity, 66. Dexamethasone.

DOWN: 1. Autoimmune, 2. One, 3. Tic, 4. Nose, 6. Edge, 7. Trim, 8. Eleven, 9. BS, 11. Uro, 12. Genital, 14. Pheo, 15. Reticularis, 17. Sipple, 18. Diabetes, 19. Schmidt's, 21. Potassium, 26. Glomerulosa, 28. Cortex, 30. Its, 32. Vow, 36. AR, 37. Sodium, 38. Own, 43. Cushing's, 44. Lethargy, 47. Hit, 48. Corti, 50. AC, 51. Let, 52. Glucose, 56. Hot, 58. ACTH, 59. Two, 61. Was, 62. Hex, 63. Doe, 64. XO

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"All some folk want is their fair share — and yours."

Arnold Glasgow

Office Self-Defense

Embezzlement is a crime of opportunity. A dishonest employee may be tempted to steal if the conditions exist to do so without being detected. I have seen such conditions in almost every medical practice with which I have consulted.

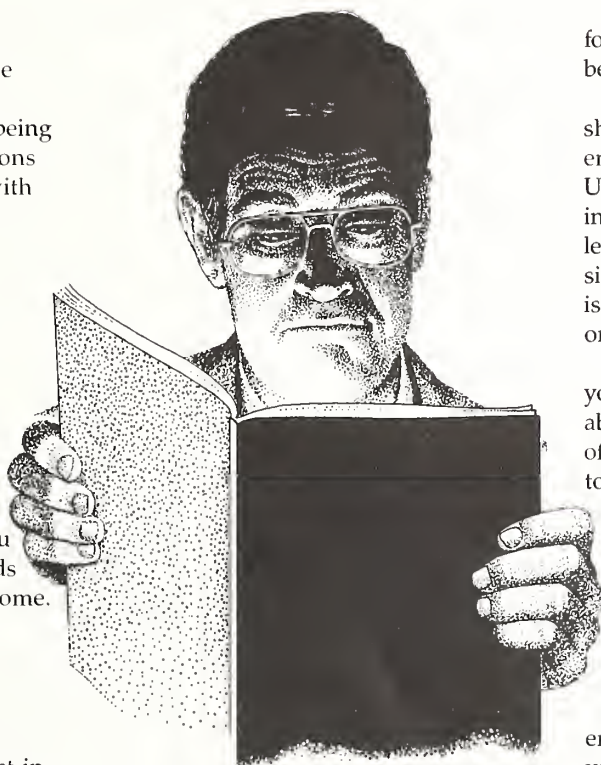
A steady embezzler can steal thousands of dollars from you each year by altering just **one** of the **hundreds** of transactions that occur in your practice each week. The improper transactions may be buried in your records and camouflaged to appear legitimate. To add insult to injury, the Internal Revenue Service has ruled that you must pay taxes on embezzled funds that have not been declared as income.

How Embezzlers Operate

Most opportunities for embezzlement in your practice exist in your billing system. Poor record keeping can hide "mistakes" such as: failure to record charges and/or payments; payments posted to a patient's ledger but not to the day sheet and/or bank deposit slip; payments recorded as adjustments; altered figures on patient ledgers and/or day sheets.

The objective of all of these techniques is to give the patient's account the appearance of being "paid." Although there are many variations on this scheme, the net result is that the employee pockets the cash.

A computerized billing system alone will not protect you from embezzlers. In fact, the reams of printed reports can hide many deceptions. A favorite ploy is to blame the computer for a contrived "error" and enter a



A common sense guide for reducing embezzlement

By Jack Valancy

transaction to "correct" it.

Your accounts payable system is another target of embezzlers. You may even be used as an unwitting accomplice. A check to a fictitious creditor may be buried among a stack of legitimate checks requiring your approval. The embezzler hopes you will rush through signing the checks without raising any questions. A

forged can alter a check after it has been signed by you.

Overpayments to vendors may be shared by your employee and a thief employed by the vendor. Unscrupulous vendors may provide inferior quality merchandise or deliver less than the quantity invoiced. A simple but effective method of stealing is to overcharge you for several items on your order.

Petty thieves may be attracted to your practice's petty cash fund. The absence of receipts and other records of expenditures makes it easy for them to remove small sums without fear of getting caught. Making informal shortterm loans from petty cash is almost giving away money.

Reducing the Opportunities for Embezzlement

The clever and determined embezzler can find a way to steal from you despite any system. Since embezzlement is a crime of opportunity, the typical embezzler will choose to work where the opportunities are greatest. Following are some common sense methods for eliminating most of the opportunities. Use them and you will foil most embezzlers.

Controls.— Almost all billing systems have built-in control mechanisms; follow them. Totals of charges, payments and adjustments should be computed from patient encounter forms and compared to the corresponding day sheet totals.

Errors should be reconciled as soon as possible. The total accounts receivable balance should be updated daily. The accounts receivable should be "proofed" or compared to actual patient account balances on a periodic basis.

Encounter forms should be prenumbered and used in sequence to assure that transactions are recorded. Patient names in the appointment book should be compared to day sheet entries to be sure all visits have been recorded.

Use written purchase orders to confirm all purchases, even those made on the phone. Use the purchase order to verify type, quantity and price of merchandise when it is delivered. Compare the purchase order to the invoice before approving payment.

Maintain complete records of all petty cash expenditures. Do not make loans to employees from the petty cash fund. Replenish the fund to the predetermined level on a regular basis.

Monitor Activities. — Review all control documents on a periodic basis. Perform spot checks of all financial functions including bank deposits, checking account reconciliation, paid bills, patient ledgers, insurance claims,

and the appointment book and day sheet. Determine that all procedures are being followed. Question any irregularities.

Do not tolerate sloppy records. If errors are made in posting, have your staff cross them out with a **single line**. Do not use opaque correction fluid to hide mistakes.

“Maintain accurate written procedures in order to reduce your dependence on an individual employee.”

Document Procedures.— Maintain accurate written procedures in order to reduce your dependence on an individual employee. Be sure to spell out exactly why and how adjustments

are made, documentation that must be maintained, and all authorizations required. Train at least two employees in each procedure so that one may recognize errors in the other's work.

Barriers.— Physical barriers, such as the arrangement of furniture, may be used to restrict access to areas containing currency, checks and financial records. A locked cash drawer may provide additional security during the day. **Never** leave cash or checks in the office overnight. If payments cannot be posted before the end of the day, make photocopies of checks for use the next day.

A checkwriting machine may be used to emboss the amount and payee on checks. This protection makes them virtually impossible to alter.

Separation of Duties.— If possible, divide tasks among employees. For example, one person opens the mail

Continued on page 38



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**Treat the symptoms in the geriatric patient...
apathy, irritability, forgetfulness and confusion**

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SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

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INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

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At OMIM, cost containment is a commitment to action. To do more than pay claims efficiently. To be concerned that the services we pay for are appropriate, necessary and economical.

These are the goals of the OMIM Medical Necessity Program. Through this Ohio State Medical Association-supported program, certain diagnostic and surgical procedures, identified as outmoded or ineffective by medical specialty societies, are no longer paid routinely.

Claims for these services are paid only when accompanied by documented evidence that they were appropriate and medically necessary under the circumstances.

If there are questions about a decision, the claim will be referred to the relevant specialty society for review.

For more information about the Medical Necessity Program, contact your area Professional Relations office or contact OMIM Provider Affairs, P.O. Box 425, Worthington, OH 43085.

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compare the analgesic effect

A *Motrin* 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients.

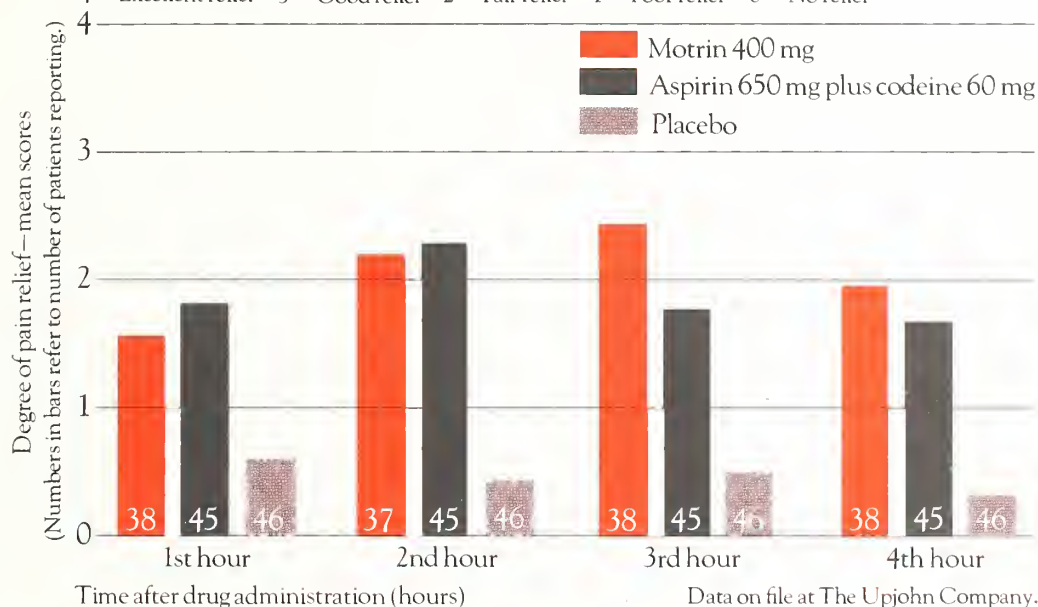
In this double-blind, placebo-controlled, randomized study, no statistically significant difference in relief of pain was noted at 1, 2, and 4 hours between the *Motrin* and aspirin-with-codeine groups... with *Motrin* being significantly more effective ($p = 0.03$) at the three-hour interval.

Active treatment was significantly more effective ($p < 0.0001$) than placebo at all time intervals.

Comparison of pain relief

Motrin vs aspirin-codeine combination

4 = Excellent relief 3 = Good relief 2 = Fair relief 1 = Poor relief 0 = No relief



One tablet q4-6h prn

For relief of mild to moderate pain:

Motrin[®] 400mg TABLETS
ibuprofen, Upjohn

- Not a narcotic • Not addictive • Not habit forming • Nonscheduled
- Acts peripherally • Relieves pain rapidly • Relieves inflammation • Indicated in acute and chronic pain • Well tolerated (The most common side effect with *Motrin* is mild gastrointestinal disturbance.)

Please turn the page for a brief summary of prescribing information.

Upjohn

Motrin® (ibuprofen)

now proved an effective analgesic for mild to moderate pain

Motrin® Tablets (ibuprofen, Upjohn)

Indications and Usage: Relief of mild to moderate pain.

Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in long-term management. Safety and efficacy have not been established in Functional Class IV rheumatoid arthritis.

Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. Aspirin used concomitantly may decrease Motrin blood levels.

Coumarin: Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena.

Central Nervous System: Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

Dosage and Administration: Rheumatoid arthritis and osteoarthritis, including flares of chronic disease: Suggested dosage is 300, 400 or 600 mg t.i.d. or q.i.d. Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for relief of pain.

Do not exceed 2400 mg per day

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For additional product information, see your Upjohn representative or consult the package insert.

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MED B-4-S

Healthy people

(continued from page 11)

promoted by all 50 state auxiliaries and more than half of the 1,000 county medical organizations. This effort is consistent with the AMA Program.

As a further evidence of the AMA commitment to the improvement of lifestyles, programs for improved diet and physical fitness, cessation of cigarette and alcohol consumption, control of stress and obesity will be initiated for AMA employees by the Department of Health Education. Similar programs will be developed for physicians and the public on the basis of this experience with AMA staff.

Office Self-Defense

(continued from page 28)

and prepares the bank deposit, another person posts payments; one person orders supplies and services, another person prepares the checks.

Many banks provide lockbox service for their customers. Patients mail their payments to a post office box, the bank picks up the mail, deposits the payments to your account and sends you photocopies of the checks along with other items. Your staff uses these to post payments to patient accounts. An embezzler will have a difficult time stealing money that does not enter the office.

Fidelity Bond.— A fidelity bond insures you against loss from theft by your employees. Bonding your employees has both positive and negative connotations about your view of their honesty. Consider this option carefully.

Conclusion

No employer intentionally hires dishonest people. Every employer risks loss by embezzlement. Denial of this risk will not lessen the probability of it happening to you. Your best protection is a common sense approach to reduce the opportunities for embezzlement. **CSMA**

Jack Valancy owns a practice management consulting firm in Cleveland Heights, Ohio.

Thinking of retirement?

Whether it's just around the corner, or further down the road,
you'll want to consider the following . . .

Qualified Retirement Plans*

*By James F. Mosier, J.D.
Douglas L. Freeman, CLU*

The establishment of a "Qualified Retirement Plan" is an extremely effective means of providing both retirement income for the physician and a tax shelter for a substantial portion of current income. A "qualified" plan is one designed in accordance with regulations set forth under the Employee Retirement Income Security Act (ERISA) of 1974, and subsequently approved by the Internal Revenue Service (IRS). The "qualification" of a retirement plan is essential in reaping the tax advantages of contributing to such a plan, namely:

- (1) Contributions are tax deductible.
- (2) Investment income on contributions is tax deferred.

The recent passage of the Economic Recovery Tax Act (ERTA) in August of 1981 enhances the tax advantages of qualified plans. This article reviews the three categories of plans — Individual Retirement Accounts, Keogh (H.R. 10) Plans, and Corporate Pension Plans — in light of the new tax laws.

INDIVIDUAL RETIREMENT ACCOUNTS (IRAs)

Very few physicians have established IRAs in the past for the basic reason that very few have been eligible to do so. Under previous federal tax law, active participants in either a corporate retirement plan or a Keogh plan were prohibited from establishing an IRA. However, this restriction was removed with the passage of ERTA. For tax years that begin after December 31, 1981, anyone is eligible to establish an IRA if two requirements are met: you must not yet be 70½ years of age, and you must have "earned income" (wages, salary, or professional fees).

Beginning January 1, 1982, you can contribute up to \$2,000 per year to an IRA. This contribution earns interest free of current income tax and the amount of your contribution is fully tax deductible. The deduction is from gross income; therefore, even if you do not itemize, the deduction is still

available. If you have a nonworking spouse, you can contribute and deduct up to \$2,250 per year; however, no more than \$2,000 of this \$2,250 can be allocated to your or your spouse's account in any single tax year. Of course, if both you and your spouse have "earned income," you are both eligible to establish your own IRAs in the amount of \$2,000 each.

Along with the tax advantages of deductibility and tax-free accumulation of interest, federal tax law imposes restrictions on when and how you can withdraw funds from your IRA. It is considered a premature distribution with severe tax penalties imposed if you withdraw any funds for your personal use before you reach age 59½, borrow from your IRA, or pledge any part of your IRA as collateral for a loan. You can begin to receive your IRA funds, without a tax penalty, when you reach age 59½; you must begin to receive distribution of your IRA funds no later than the close of the taxable year in which you reach

***New and improved, thanks to the economic recovery act of 1981**

age 70½. It should be noted here that you may receive your IRA funds before you reach age 59½, without tax penalty, if you become disabled. When you receive distribution of IRA funds, they are taxable as ordinary income.

Federal law gives you the right to "roll over" the funds in one IRA to another IRA; if this "roll over" is accomplished within 60 days, you owe no income tax on the transaction. Also, you may at some time receive a lump sum payment, for one of several reasons, from a corporate or Keogh plan. If you place those funds in an IRA within 60 days, you will owe no current income tax, although distributions will be taxed as ordinary income when actually received by you from the IRA.

Since you (and tens of millions of others) will be eligible, as of January 1, 1982, to establish an IRA, insurance companies, savings and loans, banks and mutual funds will be competing for your \$2,000 (or \$2,500) annual contribution. As described above, many features of IRAs (eg, amount of contributions and forms of distribution) are standardized by ERISA. However, you will want to inquire as to the following features:

- Is there a "front end load," or sales commission, subtracted from your IRA contribution? Or is your entire \$2,000 contribution credited to your account?
- What is the annual administration fee?
- Is there a guaranteed rate of return?
- Is there a "back end load," or withdrawal penalty, if you decide to "roll over" your IRA funds to another financial institution?

KEOGH (H.R. 10) PLANS

Keogh (H.R. 10) Plans may be established by self-employed physicians, who are either sole proprietors or partners.

Thanks to the Economic Recovery Tax Act, for tax years that begin after

December 31, 1981, the lesser of \$15,000 or 15% of earned income can be contributed by an "owner-employee" (ie, a sole proprietor or partner owning more than 10% of the business). The full amount contributed can be deducted from the owner-employee's gross income.

Contributions to a Keogh by a "self-employed individual" (ie, a sole proprietor or a partner with a 10% or less ownership) cannot exceed the lesser of 25% of earned income or \$41,500 (1981 limitation). However, the maximum deduction for a self-employed individual's Keogh contribution is the lesser of 15% of earned income, or \$15,000 (for tax years beginning after December 31, 1981).

If you wish to establish a Keogh and your practice has no "owner-employees," federal law does not require you to include your "common-law employees" (ie, an employee with no ownership in the business) in the Keogh plan. However, if the Keogh includes even one owner-employee, federal law requires you to include your common-law employees. This is not an absolute requirement: common-law employees who work less than 1,000 hours in a twelve-month period and who have less than three years of service with you do not have to be included in the Keogh.

Being a "qualified retirement plan," Keogh contributions earn interest free of current income tax. As with an IRA, you cannot withdraw your funds except for disability, until you reach age 59½. In general, you must begin receiving distributions no later than the close of the taxable year in which you reach age 70½. You have a fully vested, nonforfeitable interest in all funds you contribute to a Keogh.

CORPORATE RETIREMENT PLANS

There are three basic types of qualified corporate retirement plans: (1) defined benefit plans, (2) money

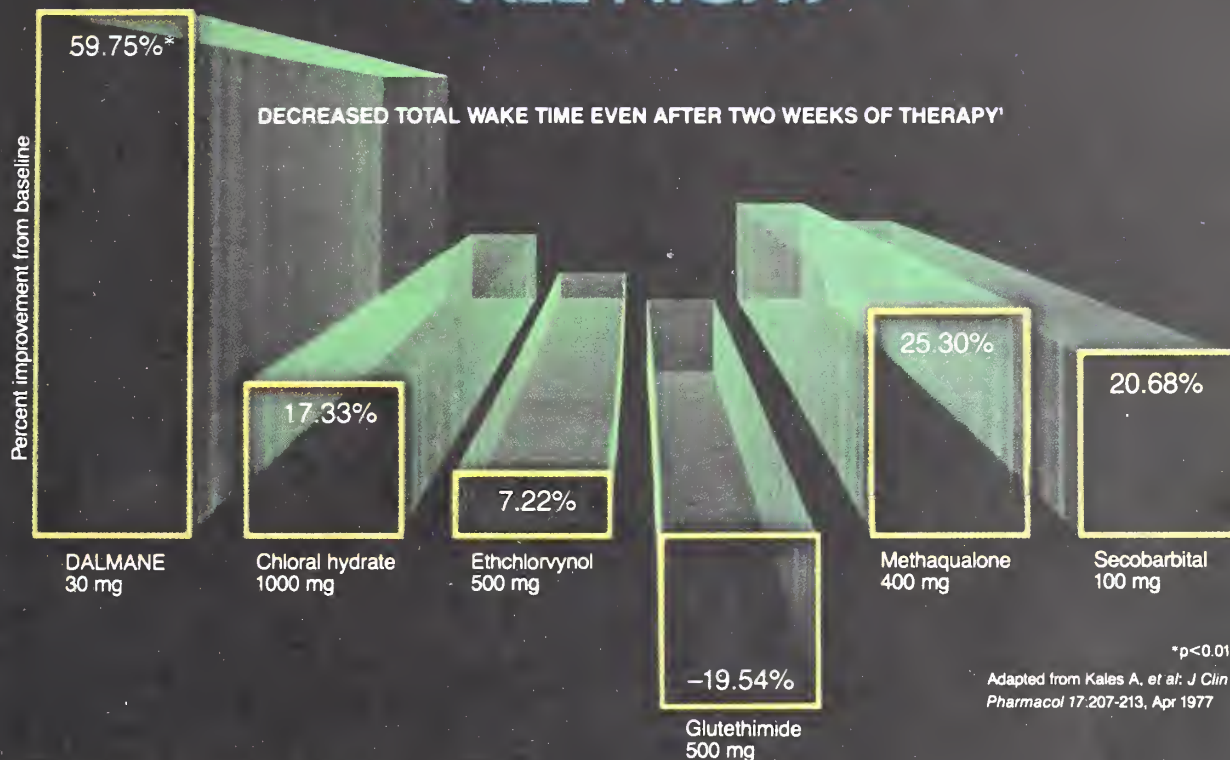
purchase plans, and (3) profit sharing plans.

As its name implies, a defined benefit pension plan emphasizes the retirement benefit itself. In a defined benefit plan, the professional corporation's employees know with certainty what their retirement benefit will be. There is no limit on the amount of money which the professional corporation can contribute to a defined benefit plan for its covered employees. The only limitation is on the amount of benefit that can be funded by the corporation. In 1981, the maximum benefit that could be funded for each employee is the lesser of 100% of the employee's average salary in his three highest years, or \$124,500; this dollar amount is adjusted upward each year to reflect inflation. In general, you must be covered by a defined benefit plan for ten years before you start receiving retirement benefits.

In a money purchase plan the professional corporation contributes a stated percentage of each covered employee's salary each year to the plan. The funds contributed for each employee are credited to that employee's individual account, along with investment gains or losses attributable to the plan. At retirement, the individual employee can withdraw the funds in his account in a lump sum or apply those funds to purchase an annuity.

A profit sharing plan is like a money purchase plan, with one important difference: while the contributions in a money purchase plan are made according to a fixed formula (eg, 5% of salary), a profit sharing plan can be designed so that the professional corporation need only make contributions when there are profits or when profits exceed a certain level. In 1981, the maximum that a professional corporation could contribute for each covered employee in a profit sharing or money purchase plan was the lesser of 25% of salary or \$41,500; this dollar amount is adjusted upward each year

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provide the optimum environment for the onset of natural sleep. If hypnotic therapy is required, it should be given for the shortest time at the lowest effective dose to achieve the desired goal.

Consider other medications the patient may be taking (including alcoholic beverages) and be aware of possible drug interactions. Please note that patients should be treated for underlying physical or psychological factors before therapy with a sleep medication is undertaken.

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- Compatible with chronic warfarin therapy; no unacceptable fluctuation in prothrombin time reported^{7,8}

UNLIKE NONSPECIFIC MEDICATIONS USED FOR SLEEP

Tricyclic antidepressants

- which are *not* sleep specific,⁹ yet are sometimes used in nondepressed patients for sleep
- which can cause transient insomnia in the elderly¹⁰
- which can require careful monitoring in cardiovascular patients¹⁰
- which have strong anticholinergic effects¹⁰

Antihistamines

- which are *not* reliable sleep-inducing agents¹¹
- which may produce stimulation instead¹¹
- which have anticholinergic effects¹¹

Major tranquilizers

- whose side effects may be troublesome for nonpsychotic patients¹²
- where tolerance for sedation appears rapidly¹²

Dalmane does not cause significant worsening of sleep beyond baseline levels upon discontinuation.⁴

References: 1. Kales A, et al. *J Clin Pharmacol* 17:207-213, Apr 1977 2. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ 3. Greenblatt DJ, Allen MD, Shader RI. *Clin Pharmacol Ther* 21:355-361, Mar 1977 4. Kales A, et al. *Clin Pharmacol Ther* 18:356-363, Sep 1975 5. Moore JD, Weissman L. *J Clin Pharmacol* 16:241-244, May-Jun 1976 6. Spiegel HE. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ 7. Robinson DS, Amidon EL. Interaction of benzodiazepines with warfarin in man, in *The Benzodiazepines*, edited by Garattini S, Mussini E, Randall LO, New York, Raven Press, 1973, pp 641-646 8. Warfarin Study. Data on file, Medical Department, Hoffmann-La Roche Inc., Nutley NJ 9. Baldessarini RJ. Drugs and the treatment of psychiatric disorders, chap 19, in Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6, New York, Macmillan Publishing Co. Inc., 1980, pp 391-447 10. Cole JO, Davis JM. Antidepressant drugs, chap 31.2, in *Comprehensive Textbook of Psychiatry II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2, Baltimore, The Williams & Wilkins Company, vol 2, 1976, pp 1941-1956 11. Douglas WW. Histamine and 5-hydroxytryptamine (serotonin) and their antagonists, chap 26, in Goodman and Gilman's *The Pharmacological Basis of Therapeutics*, ed 6, New York, Macmillan Publishing Co. Inc., 1980, pp 609-646 12. Davis JM, Cole JO. Antipsychotic drugs, chap 31.1, in *Comprehensive Textbook of Psychiatry II*, edited by Freedman AM, Kaplan HI, Sadock BJ, ed 2, Baltimore, The Williams & Wilkins Company, vol 2, 1976, pp 1921-1940

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect.

Adults: 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



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to reflect inflation.

CONCLUSION

Your qualified retirement plan or plans should be designed to meet your individual needs with regard to your practice income, disposable income requirements, age, and projected number of working years.

A few of the questions you may wish to consider, either in deciding whether to establish a new plan or in reviewing your present plan or plans, are:

(1) Do you want your corporate or Keogh plan to include a life insurance benefit?

(2) Does the income in your practice fluctuate? If so, you may want to elect a profit sharing plan instead of a money purchase plan.

(3) Do you plan to retire in less than ten years? If so, establishment of a defined benefit plan may not be appropriate for you, given the high

levels of contributions that may be required to fund your benefit.

(4) Do you plan to work past age 70½? If so, and you are a sole proprietor or a more than 10% partner, you may not wish to establish a Keogh plan. "Owner-employees" must begin to receive benefit distributions from a Keogh at age 70½.

(5) Do you want to have the opportunity to borrow your own retirement funds for personal use? This option can easily be built into corporate plans, although the loan must be "commercially feasible" with a competitive rate of interest and a definite repayment schedule. However, loans are not permitted from Keogh plans without a tax penalty.

(6) Do you want to retain control over the investment of your pension funds? This is permissible under ERISA. On the other hand, you may wish to turn the investment function over to an experienced third party.

(7) Should you incorporate? ERISA permits larger contributions for corporate employees than in Keoghs and IRAs. You may wish to ask your benefits adviser to do an incorporation feasibility study on your practice.

As these questions indicate, numerous decisions are required to be made in the setting up of a qualified retirement plan. The purpose of this article is to provide a broad, conceptual overview of the basic characteristics of qualified plans and to emphasize the tremendous advantages which are available to the physician by judicious use of these plans. Because of the tax advantages granted to qualified plans, they are the best means available today of providing retirement income and sheltering current income. **OSMA**

James F. Mosier is Vice President of PICO Life and Douglas J. Freeman is Assistant Vice President, PICO Life.

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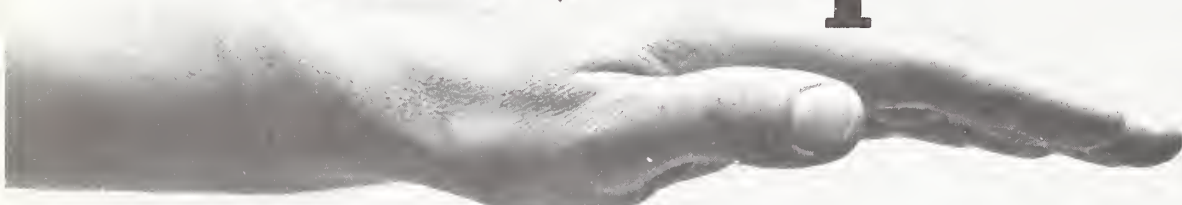
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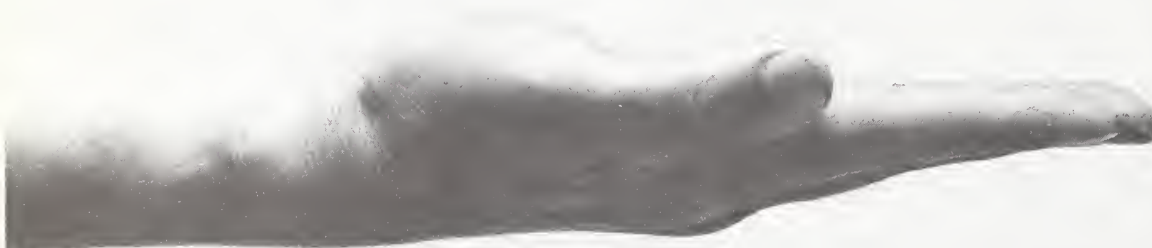
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(An Update)

The OSMA Committee on Membership is pleased to note that 600 new members have been added to membership rolls this year. This modest increase, coupled with the addition of 4,100 student and resident members, have enabled the OSMA membership to reach an all-time high of 16,447. But before we indulge in too much self-congratulation we should recall that there still are more than 6,000 Ohio doctors who don't belong to any part of the AMA federation. And the recent increase in competition among medical organizations for the dues dollar has forced some concern over retention of current members.

"Why should doctors continue to join the OSMA and the AMA?" is the question which has led both organizations to engage in critical self-examination of services and functions. In a world of ever-increasing restrictive legislation on medical practice and mushrooming interposition of third parties between the doctor and the patient, it shouldn't be surprising that a recent survey by the AMA has identified advocacy and representation as services most desired and expected of the state and national medical organizations.

The OSMA has anticipated this and has already assigned high priority to these services, which it feels better

By Thomas A. Morgan, M.D.

prepared to provide than any other medical organization in our state. A new and exciting advocacy program has been added by the Department of Government Relations and the activity of the Legislative Department has been undergoing steady expansion for the past few years.

A new and exciting advocacy program has been added by the Department of Government Relations

ADVOCACY

The ever-increasing complexities of the computer age have led directly to the development of a new advocacy service by the Department of Government Relations, which is already assisting many physician members in their dealings with both private and bureaucratic third parties.

Although this new "ombudsman"

program is only two years old, Government Relations Director David Pennington estimates it has been responsible for returning approximately \$500,000 in unpaid bills to physician members this year. In this service, the OSMA intercedes as ombudsman for physician members with third-party payers, such as Medicaid and Medicare, and also with insurance companies when reimbursement for services is denied or considered inadequate.

An increasing number of member/physicians have already been recipients of more reimbursement dollars from this service than the amount of their membership dues. We know of no other organization that can provide such a windfall return on a dues investment.

All a member has to do to avail himself of this valuable service is to provide the pertinent information to Mr. David Pennington, Director of Government Relations at OSMA. This service alone should persuade nonmembers to join the OSMA, particularly if payment of dues is their stated reason for not joining.

REPRESENTATION

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of medicine were introduced. There is no way that the individual physician or even the various specialty societies with their understandably narrow range of interest could begin to cope with this avalanche of mostly restrictive legislation. Only a board-based organization with a profession-wide perspective can hope to deal in a practical sense with an onslaught of this kind.

Obviously, only the OSMA at the state level and the AMA at the national level possess the kind of professional perspective needed to contribute in a coherent way to the legislative process. All too often, lately, legislators have complained that they encounter such divergent positions on legislative proposals from

The development of the legislative function is mandatory if we are to avoid . . . bureaucratic strangulation."

different specialty societies (acting independently), that they cannot vote in a responsibly informed manner on medical issues, even though they may be inclined to be helpful.

The OSMA Department of State and Federal Legislation under the direction of D. Brent Mulgrew, Esquire, has had unparalleled success in the past few years presenting the opinions of organized medicine in the legislative arena. An outstanding example of the OSMA's recent success was the passage of legislation (SB 271) in 1979 that mandated the return of more than \$25 million dollars to Ohio's physicians from the Stabilization Reserve Fund established during the "1975 malpractice crisis." The department presently is working to return the remaining \$18 million SRF dollars held by the State of Ohio.

For the past four years the OSMA has opposed proposed legislation that would permit nonmedically trained optometrists to administer diagnostic drugs — without adequate educational and clinical experience. This legislation, if enacted, would open the

door for other nonmedical practitioners' use of drugs and the OSMA to date has been instrumental in preventing this type of legislation being enacted into law.

The OSMA is now working toward passage of legislation (HB 173) that, if enacted, would specify in Ohio law that all patients admitted to a hospital must be under the medical supervision or care of a physician. The bill would also delineate that only physicians and dentists may independently admit patients to a hospital.

The Department successfully defeated a proposed mandatory reporting of malpractice claims and hospital staff privilege limitations in the pending state medical board bill (HB 317). The Department amended a bill to protect the individuals who report information to hospital credentials committees (HB 51) and amended the budget to abolish the medical board requirements of filing CME log books. Also in the proposed budget were OSMA proposals to require a 45-day turnaround maximum

for Medicaid payments, after which interest payments would be made to the physician, and creation of a legislative study commission to investigate the rate of physician reimbursements under this program.

And so, responding to a perceived need of the medical community, the OSMA has developed an effective, aggressive Department of Legislation. The department's coherent presentation of the opinions and recommendations of the entire medical profession has helped legislators deal with the steadily increasing number of proposals which would lead to fundamental changes in the way medical care is delivered to people. One need not add that many of these changes, if enacted, might be quite destructive in their impact on the quality of health care.

The development and enlargement of the legislative function is mandatory if we are to avoid deterioration in quality of care through bureaucratic strangulation of the medical profession.

The practical facts supporting universal physician membership in OSMA are, bluntly stated:

1. The new ombudsman service offers an opportunity for members to recoup part or all of their dues dollars by interceding with public and private third parties on behalf of OSMA members.

2. Organizations which hope to have a significant impact on large bureaucracies, public or private, must operate from strength which translates into numbers. A single individual or even small organizations generally have little impact on legislators, bureaucracies or multimillion dollar health insurance companies. But when an OSMA representative can state authoritatively that he represents more than 20,000 doctors, he has an attentive audience as vastly increased. In a word, he has "clout." OSMA membership provides the clout we need. In today's world we can't afford to be without it! **OSMA**

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INTERNIST: In July 1980 will be available for practice and eligible for specialty board exam. Seeking solo or small group practice in community that is rural with metropolitan ties, suburban metropolitan or metropolitan with population of 15,000-100,000. Contact Box P-60 c/o Ohio State Medical Journal.

INTERNIST: With subspecialty of endocrinology and metabolism. Board-eligible in internal medicine in 1979 and in endocrinology in 1981. Interested in solo or group practice and part-time academic appointment. Contact Box P-82 c/o Ohio State Medical Journal.

OPHTHALMOLOGIST: Will be board eligible and available for practice in July 1982. Desires solo or group practice in area 2, 3 or 5 in community that is rural with metropolitan ties and has 15,000 to 100,000 population. Contact Box P-85 c/o Ohio State Medical Journal.

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Obituaries

DONALD CHICKERING, M.D., Warren; Case Western Reserve University School of Medicine, 1944; age 60; died October 25, 1981; member OSMA and AMA.

ALEXANDER CHOMYN, M.D., Lima; Akademia Medyczna, Krakow, Poland, 1928; age 84; died 1981; member OSMA and AMA.

WILLIAM L. DONHAM, M.D., Lima; Indiana University School of Medicine, Indianapolis, 1942; age 63; died 1981; member OSMA and AMA.

GWILYM A. EDWARDS, M.D., Hot Springs, Arkansas; Vanderbilt University School of Medicine, Nashville, 1935; age 71; died 1981; member OSMA and AMA.

KENNETH G. HAWVER, M.D., Naples, Florida; Ohio State University College of Medicine, 1930; age 77; died 1981; member OSMA and AMA.

RICHARD J. JARVIS, M.D., Youngstown; University of Cincinnati College of Medicine, 1958; age 54; died October 17, 1981; member OSMA and AMA.

DAVIS C. MIDDLETON, M.D., Dayton; Hahnemann Medical College and Hospital, Philadelphia, 1921; age 83; died October 24, 1981; member OSMA and AMA.

SYLVESTER MISSAL, M.D., Cleveland; University of Michigan Medical School, Ann Arbor, 1935; age 73; died October 2, 1981; member OSMA and AMA.

JACOB E. PALOMAKI, M.D., Cleveland; Case Western Reserve University School of Medicine, 1934; age 71; died October 8, 1981; member OSMA and AMA.

ROBERT E. REIHELD, M.D., Orrville; Ohio State University College of Medicine, 1941; age 65; died June, 1981; member OSMA and AMA.


KARL F. RITTER, M.D., Lima; Eclectic Medical College, Cincinnati, 1936; age 78; died 1981; member OSMA and AMA.

EDGAR ANDREW SHERK, M.D., Dayton; University of Cincinnati College of Medicine, 1925; age 82; died October 17, 1981; member OSMA and AMA.

EDWARD STEINKOPFF, M.D., North Port, Florida; University of Illinois College of Medicine, Chicago, 1929; age 77; died 1981; member OSMA and AMA.

GEORGE C. STERNAD, M.D., Eastlake; Case Western Reserve University School of Medicine, 1920; age 86; died October 13, 1981; member OSMA and AMA.

CARL R. SWANBECK, M.D., Sandusky; Case Western Reserve University School of Medicine, 1943; age 63; died October 28, 1981; member OSMA and AMA.



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By R. M. Benson, M.D.

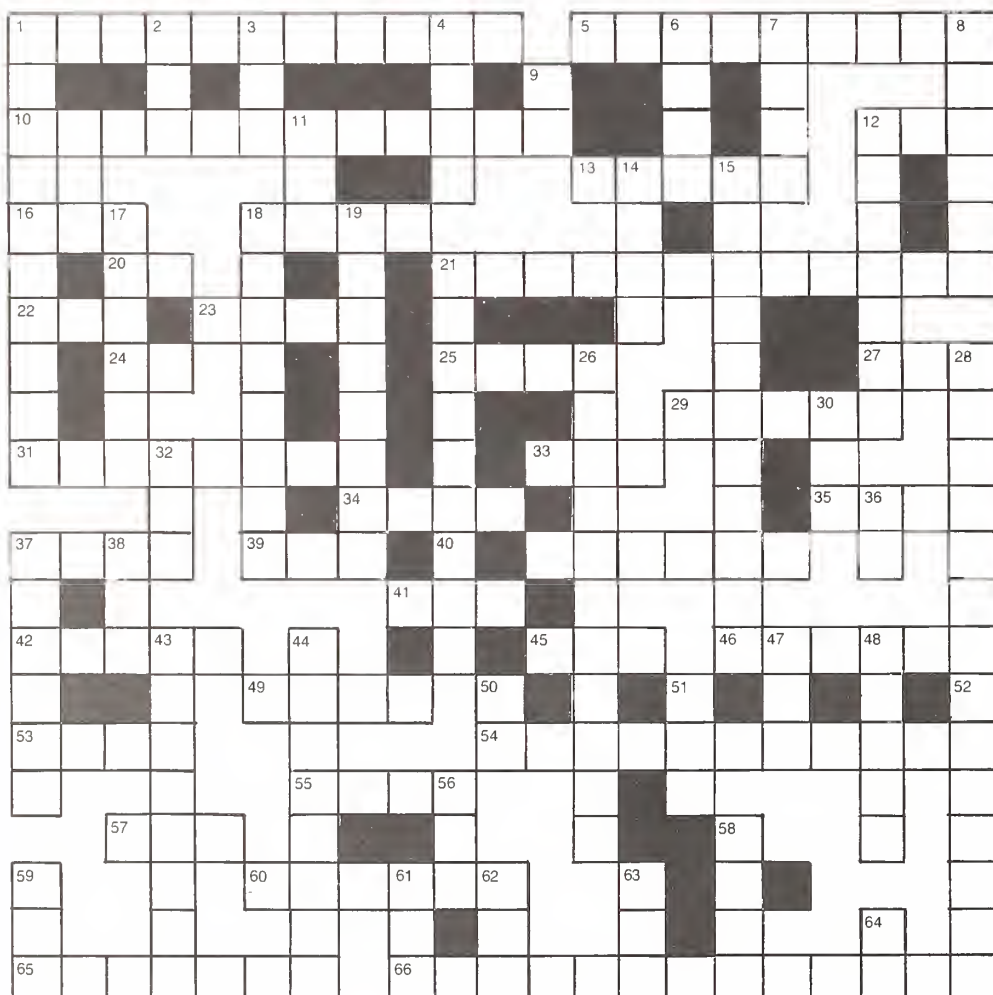
ADRENAL

ACROSS:

1. Adrenal glomerulosa hormone exchanging sodium for potassium, 5. Most common hydroxylase defect in A-G Syndrome, 10. Common cause of Addison's disease in the early twentieth century, 12. — whiz!, 13. Male reproductive cells, 16. Government agency popular on April fifteenth, 18. Prescribed amount of medicine, 20. Route of giving Solucortef, 21. Skin feature increased in Nelson's Syndrome, 22. Swab, 23. Humerous poet preferring liquor to candy, 24. Measurement of ionic hydrogen, 25. Small branch, 27. Glycosylated hemoglobin, 29. Opening of the eye, 31. Seventeen hydroxyprogesterone in common form of adrenogenital syndrome, 33. Cortisol levels in Schmidt's Syndrome, 34. Throw, 35. Aldosterone aids its retention, 37. Relaxation phase of DTR in hypothyroidism, 39. Female family member, 40. Not after, 41. Closest star to earth, 42. Person not enjoying this puzzle, 45. Renal chemistry elevated in hypovolemia, 46. Occasional clinical presentation of two week old male with adrenogenital syndrome, 49. Urine metabolites of adrenal androgens seventeen — steroids, 53. Employs, 54. Steroid precursor, 55. ACTH levels in Addison's Disease, 57. Method of hormone measurement, 60. Increase in size, 65. Adipose state in Cushing's, 66. Low and high dose aid in diagnosis of forty three down.

DOWN:

1. Hashimoto's thyroiditis, 2. MEA type with pancreatic and pituitary tumors, 3. Nervous twitch, 4. Olfactory organ, 6. Outer border, 7. Thin, 8. Hydroxylase defect in hypertensive virilizing A-G Syndrome, 9. This puzzle or undergraduate degree, 11. Anlage of lower vagina —, genital sinus, 12. Cortisol enzyme deficiency adreno — Syndrome, 14. Adrenal medulla tumor — chromocytoma, 15. Adrenal zone source of androgens, 17. MEA type II — Syndrome, 18. Pancreatic endocrinopathy frequently associated with childhood Addison's, 19. Syndrome combining Addison's and Hashimoto's, 21. Cation elevated in adrenal insufficiency, 26. Adrenal zone source of aldosterone, 28. Adrenal layer controlled by ACTH, 30. Belonging to it, 32. Oath, 36. (Abbr) Genetics of adrenogenital syndrome, 37. Cation low in adrenogenital shock, 38. Possess, 43. Syndrome of hypercortisolism, 44. Energy in Addison's disease, 47. Strike, 48. Urine cortisol metabolites seventeen hydroxy — costeroids, 50. Partner of DC, 51. Allow, 52. Measured with diastix, 56. Not cold, 58. Pituitary hormone modulated by cortisol, 59. Sipple's MEA type, 61. Used to be, 62. Evil spell, 63. Bambi's mother, 64. Common Turner Karyotype.



(solution is on
page 25)

Dr. Benson is the Director of
Pediatric Endocrinology at
Children's Hospital
Medical Center, Akron.

The Parkinson patient

To the Editor:

May I introduce myself as a "Parkinsonian" of 21 years standing? To get away from my handicaps, I am still trying all possibilities — only to find a "no exit" sign everywhere. However, I have developed a method to aid the unsteady patient to walk (see below). Of course this is not a cure but I have found it to be a great help in boosting morale and confidence. (To encourage an estimated 300,000 patients would be a worthwhile accomplishment.) Give it a try.

Sincerely,
/s/Walter de la Motte, M.D.
Worthington, Ohio

If the patient cannot walk because his feet seem to "stick to the ground," a bystander will usually offer to help by grasping the patient's arm. This unilateral approach, however, will aggravate the patient's imbalance and cause the individual to lean his or her entire weight on the hapless Good Samaritan. In this situation the following procedure is helpful:

- The assistant steps up to the patient, face to face.
- The patient and his assistant hold hands as if they were dancing.
- The patient steps backward out of the blocked position and follows this immediately with long forward strides.
- The assistant, while still facing the patient, moves backward, coaxing the patient to maintain large steps and an erect posture.



Letters
...to the editor

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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahoglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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COLLEAGUES IN THE NEWS



ROBERT S. DANIELS, M.D., Cincinnati, was named acting director and senior vice president of the University of Cincinnati Medical Center.

DANIEL J. HANSON, M.D., Toledo, was elected to the board of trustees of Mercy Hospital.

PAULINE HIXSON, M.D., Findlay, was appointed medical director for the Emergency Medical Systems of West Central Ohio, Inc. Dr. Hixson is director of Blanchard Valley Hospital's Emergency Department.

BARTH HOOGSTRA滕, M.D., Cincinnati, was appointed medical director of Bethesda Oak Hospital's Cancer Treatment Center. Dr. Hoogstraten's interest is in cancer chemotherapy and the study of patients on treatment protocol. He has been a member of the National Cooperative Cancer Treatment Groups since 1957, for the past nine years was chairman of the Southwest Oncology Group, and is currently a consultant to the Cancer Care Centers at the University of Hawaii and UCLA. Dr. Hoogstraten is the editor of two books, the author of more than 130 published articles, editor-in-chief of CRC Press for books on cancer therapy, and serves on the editorial board of three scientific journals.

BRUCE JANIAC, M.D., Toledo, was elected secretary-treasurer of the American College of Emergency Physicians. Dr. Janiak is director of the emergency department at Toledo Hospital.

NELLIE JUSKENAS, M.D., anesthesiologist, and **GORDON FARNER, M.D.**, orthopedic surgeon, were honored for 25 years of service at Marymount Hospital.

WILLIAM MAHONEY, M.D., was reelected to his second two-year term as Mayor of Olmsted Falls. Dr. Mahoney is in private practice and is a former chief of medical staff at Southwest General Hospital.

LEONARD PRITCHARD, M.D., Columbiana, was presented the Lifetime of Service Award by the Chamber of Commerce. Dr. Pritchard has been in family practice since 1954.

G. TERENCE REULAND, M.D., Springdale, testified before Congressman Tom Luken's subcommittee on health and environment in Washington on October 15, urging continuation of a strong federal clean air act. He spoke on behalf of the American Association for Respiratory Therapy. Dr. Reuland is a pulmonary physician.

S. S. STRASSMAN, M.D., Cleveland, is serving on the Section (Executive) Committee of the American Academy of Pediatrics, Section on Adolescent Health, and has been reappointed Director/Program/Meetings for the Adolescent Section. Dr. Strassman is an associate clinical professor of pediatrics at Case Western Reserve University.

JOHN M. TEW, JR., M.D., Cincinnati, was elected president-elect of the Congress of Neurological Surgeons. Dr. Tew has served on the Executive Committee of the Congress for several years and is presently chairman of the Joint Committee on Education of the Congress of Neurological Surgeons and American Association of Neurological Surgeons.

Dr. Tew also was appointed consultant in surgery to the Department of Surgery, United States Air Force Medical Center, Wright Patterson Air Force Base.

WALTER WILDMAN, M.D., Cincinnati, was elected president, **JOHN POTTSCHMIDT, M.D.**, Cincinnati, vice president, and **LOWELL GOLTER, M.D.**, Cincinnati, secretary-treasurer of the medical and dental staff of Christ Hospital. Dr. Wildman is a member of the attending staff in anesthesiology; Dr. Pottschmidt is a member of the obstetrics-gynecology staff; and Dr. Golter is a member of the internal medicine department.

"Colleagues in the News" is sponsored by



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Colleagues (continued)

CARLOS ALVAREZ, M.D., Circleville, was named medical director for Pickaway Manor Nursing Home. Dr. Alvarez has been a practicing physician and surgeon in Circleville since 1960, and is president of the medical staff of Berger Hospital.

LOUIS P. BALDONI, M.D., Toledo, was elected a board member of the Toledo and Lucas County Academy of Family Practice Physicians.

JEFFREY A. CIANCHETTI, M.D., Fairfield, was named acting medical director of the emergency department at Mercy Hospital South. Dr. Cianchetti also is medical director of the emergency department at Mercy Hospital North in Hamilton.

ROBERT O. CUNNINGHAM, M.D., Dayton, was appointed associate professor in the Wright State University Department of family practice and associate director of the Integrated Family Practice Residency Program.

ALVIN H. CRAWFORD, M.D., Cincinnati, was elected to serve two years as national chairman of the orthopedic section of the National Medical Association. Dr. Crawford is director of pediatric orthopedics at Children's Hospital Medical Center and professor of pediatrics and orthopedics at the University of Cincinnati College of Medicine.

ANGELO DEMIS, M.D., North Canton, was installed as president of the Aultman Hospital medical staff. Dr. Demis is an oncologist/hematologist. **PAUL W. WELCH, M.D.**, North Canton, was named president-elect.

CONRAD JAVIER, M.D., Cleveland, was elected president of the St. Alexis Hospital medical staff. Dr. Javier is a cardiologist.

JAMES A. JONES, M.D., Mansfield, was honored by the Richland County Children Services Board and Children Services officials for 20 years of service to the agency and its foster children.

ALLAN B. KIRSNER, M.D., Toledo, was appointed chairman of the Ohio Arthritis Committee of the Ohio Department of Health's Arthritis Program. Dr. Kirsner is clinical associate professor of medicine at the Medical College of Ohio and director of rheumatology.

Also appointed to chair the Long Range Planning Subcommittee and the Research Subcommittee were **EVELYN HESS, M.D.**, Cincinnati, McDonald professor of medicine, and director, division of immunology, University of Cincinnati Medical Center, and **IRVING KUSHNER, M.D.**, Cleveland, professor of medicine, Case Western Reserve University, and director, division of rheumatology and clinical immunology, Cleveland Metropolitan Hospital.

The following were elected officers of the medical staff at City Hospital, St. Marys, Ohio: **JANIS LAUVA, M.D.**, president; **SAMRITH LAORNUAL, M.D.**, vice president, and **JACK AMATO, M.D.**, secretary-treasurer.

ERNEST H. MEESE, M.D., Cincinnati, was reelected to the board of trustees of the American Cancer Society, Ohio Division, Inc. Dr. Meese is a thoracic and cardiovascular surgeon and currently serves as smoking and health adviser for the Hamilton County Unit of the American Cancer Society.

JOHN C. MELNICK, M.D., Youngstown, was named Doctor of the Year by the Mahoning County Medical Society. Dr. Melnick is director of the department of radiology and nuclear medicine at South Side Hospital, vice chief of the division of radiology at the Youngstown Hospital Association, and an associate professor of radiology at Northeastern Ohio Universities College of Medicine.

WILLIAM B. MERRYMAN, M.D., Worthington, Brigadier General, Medical Corps, U.S. Army Reserve, was awarded the Legion of Merit by the Secretary of the Army for leadership in training his own personnel and medical personnel of other reserve components. Dr. Merryman was awarded the Legion of Merit for his direction of medical units, conduct of military medical seminars for Naval, Air Force, National Guard and Army reservists. He also was involved in civilian contract training for professional skills of reservists. Dr. Merryman's private practice is in obstetrics and gynecology.

BHARAT OZA, M.D., Uhrichsville, was elected president, and **UMESH BETKERUR, M.D.**, Dover, was elected secretary of the Tuscarawas County Medical Society.

PAUL K. RIDENOUR, M.D., family practice, was installed as chief of the medical staff of St. Charles Hospital, Toledo. **THOMAS J. O'GRADY, M.D.**, thoracic-cardiovascular surgery, was elected chief-elect, and **FERNANDO CROTTE, M.D.**, general surgery, was elected secretary-treasurer.

JUAN F. SOTOS, M.D., Columbus, was elected president of the Children's Hospital medical staff. Dr. Sotos is chief of endocrinology and acting chief of nephrology at Children's Hospital.

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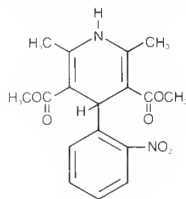
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PROCARDIA® CAPSULES

Nifedipine

For Oral Use

DESCRIPTION: PROCARDIA (nifedipine) is an antihypertensive drug belonging to a new class of pharmacological agents, the calcium channel blockers. Nifedipine is 3,5-pyridinedicarboxylic acid, 1,4-dihydro-2,6-dimethyl-4-(2-nitrophenyl)-, dimethyl ester, $C_{21}H_{18}N_2O_6$, and has the structural formula:



Nifedipine is a yellow crystalline substance, practically insoluble in water but soluble in ethanol. It has a molecular weight of 346.3. PROCARDIA CAPSULES are formulated as soft gelatin capsules for oral administration each containing 10 mg nifedipine.

CLINICAL PHARMACOLOGY: PROCARDIA (nifedipine) is a calcium ion influx inhibitor (slow channel blocker or calcium ion antagonist) and inhibits the transmembrane influx of calcium ions into cardiac muscle and smooth muscle. The contractile processes of cardiac muscle and vascular smooth muscle are dependent upon the movement of extracellular calcium ions into these cells through specific ion channels. PROCARDIA selectively inhibits calcium ion influx across the cell membrane of cardiac muscle and vascular smooth muscle without changing serum calcium concentrations.

Mechanism of Action: The precise means by which this inhibition relieves angina has not been fully determined, but includes at least the following two mechanisms:

1) **Relaxation and prevention of coronary artery spasm:** PROCARDIA dilates the main coronary arteries and coronary arterioles, both in normal and ischemic regions, and is a potent inhibitor of coronary artery spasm, whether spontaneous or ergonovine-induced. This property increases myocardial oxygen delivery in patients with coronary artery spasm, and is responsible for the effectiveness of PROCARDIA in vasospastic (Prinzmetal's or variant) angina. Whether this effect plays any role in classical angina is not clear, but studies of exercise tolerance have not shown an increase in the maximum exercise rate-pressure product, a widely accepted measure of oxygen utilization. This suggests that, in general, relief of spasm or dilation of coronary arteries is not an important factor in classical angina.

2) **Reduction of oxygen utilization:** PROCARDIA regularly reduces arterial pressure at rest and at a given level of exercise by dilating peripheral arterioles and reducing the total peripheral resistance (afterload) against which the heart works. This unloading of the heart reduces myocardial energy consumption and oxygen requirements and probably accounts for the effectiveness of PROCARDIA in chronic stable angina.

Pharmacokinetics and Metabolism: PROCARDIA is rapidly and fully absorbed after oral administration. The drug is detectable in serum 10 minutes after oral administration, and peak blood levels occur in approximately 30 minutes. It is highly bound by serum proteins. PROCARDIA is extensively converted to inactive metabolites and approximately 80% of PROCARDIA and metabolites are eliminated via the kidneys. The half-life of nifedipine in plasma is approximately two hours. There is no information on the effects of renal or hepatic impairment on excretion or metabolism of PROCARDIA.

Hemodynamics: Like other slow channel blockers, PROCARDIA exerts a negative inotropic effect on isolated myocardial tissue. This is rarely, if ever, seen in intact animals or man, probably because of reflex responses to its vasodilating effects. In man, PROCARDIA causes decreased peripheral vascular resistance and a fall in systolic and diastolic pressure, usually modest (5–10 mm Hg systolic), but sometimes larger. There is usually a small increase in heart rate, a reflex response to vasodilation. Measurements of cardiac function in patients with normal ventricular function have generally found a small increase in cardiac index without major effects on ejection fraction, left ventricular end diastolic pressure (LVEDP) or volume (LVEDV). In patients with impaired ventricular function, most acute studies have shown some increase in ejection fraction and reduction in left ventricular filling pressure.

Electrophysiologic Effects: Although, like other members of its class, PROCARDIA decreases sinoatrial node function and atrioventricular conduction in isolated myocardial preparations, such effects have not been seen in studies in intact animals or in man. In formal electrophysiologic studies, predominantly in patients with normal conduction systems, PROCARDIA has had no tendency to prolong atrioventricular conduction, prolong sinus node recovery time, or slow sinus rate.

INDICATIONS AND USAGE: I. **Vasospastic Angina:** PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. **Chronic Stable Angina (Classical Effort-Associated Angina):** PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta-blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure since severe hypotension can occur from the combined effects of the drugs. See Warnings.

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers.

Increased Angina/Beta Blocker Withdrawal: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone.

Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines. Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA.

Congestive Heart Failure: Rarely, patients usually receiving a beta blocker have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event, as the unloading effect of PROCARDIA would be expected to be of less benefit to these patients, owing to their fixed impedance to flow across the aortic valve.

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested. Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. See Warnings.

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA. This edema occurs primarily in the lower extremities and usually responds to

diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents: See Indications and Warnings. Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antihypertensive effectiveness of this combination.

Carcinogenesis, mutagenesis, impairment of fertility: Nifedipine was administered orally to rats for two years and was not shown to be carcinogenic. When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose. In vivo mutagenicity studies were negative.

Pregnancy: Pregnancy category C. Nifedipine has been shown to be teratogenic in rats when given in doses 30 times the maximum recommended human dose. Nifedipine was embryotoxic (increased fetal resorptions, decreased fetal weight, increased stunted forms, increased fetal deaths, decreased neonatal survival) in rats, mice and rabbits at doses of from 3 to 10 times the maximum recommended human dose. In pregnant monkeys, doses 2/3 and twice the maximum recommended human dose resulted in small placentas and underdeveloped chorionic villi. In rats, doses three times the maximum human dose and higher caused prolongation of pregnancy. There are no adequate and well-controlled studies in pregnant women. PROCARDIA should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.

ADVERSE REACTIONS: In multiple-dose U.S. and foreign-controlled studies in which adverse reactions were reported spontaneously, adverse effects were frequent but generally not serious and rarely required discontinuation of therapy or dosage adjustment. Most were expected consequences of the vasodilator effects of PROCARDIA.

Adverse Effect	PROCARDIA (%) (N = 226)	Placebo (%) (N = 235)
Dizziness, light-headedness, giddiness	27	15
Flushing, heat sensation	25	8
Headache	23	20
Weakness	12	10
Nausea, heartburn	11	8
Muscle cramps, tremor	8	3
Peripheral edema	7	1
Nervousness, mood changes	7	4
Palpitation	7	5
Dyspnea, cough, wheezing	6	3
Nasal congestion, sore throat	6	8

There is also a large uncontrolled experience in over 2100 patients in the United States. Most of the patients had vasospastic or resistant angina pectoris, and about half had concomitant treatment with beta-adrenergic blocking agents. The most common adverse events were the same ones seen in the controlled trials, with dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antihypertensive medication. Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

Several of these side effects appear to be dose related. Peripheral edema occurred in about one in 25 patients at doses less than 60 mg per day and in about one patient in eight at 120 mg per day or more. Transient hypotension, generally of mild to moderate severity and seldom requiring discontinuation of therapy, occurred in one of 50 patients at less than 60 mg per day and in one of 20 patients at 120 mg per day or more.

In addition, 2% or fewer of patients reported the following: Respiratory: Nasal and chest congestion, shortness of breath. Gastrointestinal: Diarrhea, constipation, cramps, flatulence. Musculoskeletal: Inflammation, joint stiffness, muscle cramps. CNS: Shakiness, nervousness, jitteriness, sleep disturbances, blurred vision, difficulties in balance. Other: Dermatitis, pruritus, urticaria, fever, sweating, chills, sexual difficulties.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients.

In a subgroup of over 1000 patients receiving PROCARDIA with concomitant beta blocker therapy, the pattern and incidence of adverse experiences was not different from that of the entire group of PROCARDIA treated patients (see Precautions).

In a subgroup of patients with a diagnosis of congestive heart failure as well as angina, dizziness or light-headedness, peripheral edema, headache or flushing each occurred in one in eight patients. Hypotension occurred in about one in 20 patients. Syncope occurred in approximately one patient in 250. Myocardial infarction or symptoms of congestive heart failure each occurred in about one patient in 15. Atrial or ventricular dysrhythmias each occurred in about one patient in 150.

Laboratory tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have already been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

OVERDOSAGE: Although there is no well documented experience with PROCARDIA overdosage, available data suggest that gross overdosage could result in excessive peripheral vasodilation with subsequent marked and probably prolonged systemic hypotension. Clinically significant hypotension due to PROCARDIA overdosage calls for active cardiovascular support including monitoring of cardiac and respiratory function, elevation of extremities, and attention to circulating fluid volume and urine output. A vasoconstrictor (such as norepinephrine) may be helpful in restoring vascular tone and blood pressure, provided that there is no contraindication to its use. Clearance of PROCARDIA would be expected to be prolonged in patients with impaired liver function. Since PROCARDIA is highly protein-bound, dialysis is not likely to be of benefit.

DOSEAGE AND ADMINISTRATION: The dosage of PROCARDIA needed to suppress angina and that can be tolerated by the patient must be established by titration. Excessive doses can result in hypotension.

The starting dose is one 10 mg capsule, swallowed whole, 3 times/day. The usual effective dose range is 10–20 mg three times daily. Some patients, especially those with evidence of coronary artery spasm, respond only to higher doses, more frequent administration, or both. In such patients, doses of 20–30 mg three or four times daily may be effective. Doses above 120 mg daily are rarely necessary. More than 180 mg per day is not recommended.

In most cases, PROCARDIA titration should proceed over a 7–14 day period so that the physician can assess the response to each dose level and monitor the blood pressure before proceeding to higher doses.

If symptoms so warrant, titration may proceed more rapidly provided that the patient is assessed frequently. Based on the patient's physical activity level, attack frequency, and sublingual nitroglycerin consumption, the dose of PROCARDIA may be increased from 10 mg t.i.d. to 20 mg t.i.d. and then to 30 mg t.i.d. over a three-day period.

In hospitalized patients under close observation, the dose may be increased in 10 mg increments over four to six-hour periods as required to control pain and arrhythmias due to ischemia. A single dose should rarely exceed 30 mg.

No "rebound effect" has been observed upon discontinuation of PROCARDIA. However, if discontinuation of PROCARDIA is necessary, sound clinical practice suggests that the dosage should be decreased gradually with close physician supervision.

Co-Administration with Other Antihypertensive Drugs: Sublingual nitroglycerin may be taken as required for the control of acute manifestations of angina, particularly during PROCARDIA titration. See Precautions. Drug Interactions for information on co-administration of PROCARDIA with beta blockers or long-acting nitrates.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA Capsule contains 10 mg of nifedipine. PROCARDIA Capsules are supplied in amber glass bottles of 100 capsules (NDC 0069-2600-66).

The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

Issued January 1982

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NEWS

a compilation of the latest developments, reports and products of interest to physicians.

edited by
Gina DiBlasio Cummins

Intensive care units may be full of unnecessary patients

Many patients admitted to intensive care units (ICU) may not necessarily need around-the-clock attention, suggests a study in the *Journal of the American Medical Association*.

Dr. William A. Knaus at George Washington University Medical Center in Washington, D.C., reports that nearly half the patients admitted to his hospital's ICU over an eight-month period actually did not need intensive treatment. Instead, these patients mainly needed close nursing attention which Dr. Knaus feels could have been accomplished elsewhere in the hospital.

The implication of this study, if the same pattern holds true nationally, is

that admissions to ICUs conceivably could be cut back without jeopardizing patient care. This would then slow the demand for more ICU beds, which has been increasing at about four percent a year.

According to Dr. Knaus, other studies have shown that for every patient admitted to the ICU not needing intensive treatment, an experienced ICU nurse is being underutilized.

With emphasis lately on improving the cost effectiveness of medical care, Dr. Knaus said that it is appropriate to take a closer look at who is being admitted to ICUs.

Cincinnati surgeon's predictions prove accurate

The bacteria linked to toxic shock syndrome are now appearing in wounds in burn victims and surgery patients at hospitals, just as Cincinnati surgeon, William Altemeier, M.D., predicted it would almost a year ago, reports a story by Mary Carmen Cupito in a recent issue of the *Cincinnati Post*.

Dr. Altemeier has been studying the characteristics of the staphylococcus aureus bacteria for about 35 years, and has discovered that every five years or so, new strains of the bacteria emerge. Some studies suggest that the strain that produces the toxin associated with toxic shock syndrome emerged in the late 1970s.

The staphylococcus bacteria has cropped up in 33 patients in the past two years at local hospitals, Dr. Altemeier claims, and other researchers from various parts of the country report that the disease also is being discovered in hospital patients.

Office personnel urged to show more respect to patients

Editor's Note: The following discussion recently appeared in the nationally syndicated column "Senior Forum" by Beulah Collins. We thought it was worth a mention here.

Q. — Due to the illness of my regular physician, I recently had to see a new doctor. A cute girl, about my granddaughter's age, showed me to the examining room and said: "The doctor will be with you in a moment, Clare."

I was both shocked and indignant at this very unprofessional behavior. Surely elderly people deserve more respect than this kind of familiarity indicates.

I brought up the subject at a recent Senior Citizens meeting and found widespread resentment among older people about this sort of thing, but most were hesitant in making their feelings known, as I am.

A. — Little enough dignity remains to a person shown into a doctor's

examining room, told to undress, and then left there, waiting, shivering and often apprehensive. It is a time and situation when a man or woman needs whatever personhood he or she can muster.

Under these circumstances, being addressed familiarly by a much younger person — as though the patient were a child or a pet — hits the average older patient exactly wrong.

Somebody must be telling these granddaughter-age nurses and helpers that using the patient's first name will help him feel more at ease. Not so. Even older people who enjoy being called by their first names by younger friends in pleasant social situations, rarely care for this familiarity from a young aide in a doctor's office, often an aide whom they have never met or even seen before.

Take heed, doctors.

Meetings

Update of Surgery; March 4-6, 1982; Turner Auditorium, Baltimore, Maryland. Topics include vascular surgery, trauma and critical care. Sponsored by the Johns Hopkins Medical Institutions, registration fee \$300. For further information, contact: Program Coordinator, Turner 22, 720 Rutland Ave., Baltimore, Maryland 21205.

Conscience and Conduct; March 6-7, 1982; Loyola of the Lakes Ritual House, Clinton, Ohio. Part of the Third Annual Physician Spiritual Retreat. Sponsored by the Northeast Ohio Universities College of Medicine and the Timken Mercy Medical Center, Department of Psychiatry. For more information, contact: Dr. Joseph W. Kolp at 216-456-5054 or Dr. John Kuehn, 216-489-1241.

Cancer Symposium "Adjuvant Chemotherapy Update"; March 10, 1982; Stouffer's Inn on the Square, Cleveland, Ohio. Sponsored by the Northeast Ohio Society for Clinical Oncology and American Cancer Society, Ohio Division, Inc. For further information, contact: Frances Helmick, R.N., Director, Professional Education, ACS, Ohio Division, Inc., 1375 Euclid Avenue, Rm. 312, Cleveland, Ohio 44115.

PICO helps form PRORECO

The Physicians Insurance Company of Ohio (PICO) will be joining the Physicians Insurance Companies of Kentucky and Michigan in the formation of PRORECO Reinsurance Corporation, Ltd., a reinsurance company, organized under the laws of the Cayman Islands, British West Indies.

David P. Kaechele, Executive Vice President of PICO has been elected to serve as the Chairman of the Executive Committee of PRORECO's Board of Directors.

Lunar Effects — Fact or Fiction?



Folklore has long held the full moon responsible for the creation of vampires, werewolves and other things that go bump in the night, but scientists are beginning to suspect the moon might also be a culprit in some of man's more mundane maladies.

Ralph W. Morris, Ph.D., a professor of pharmacology at the University of Illinois Medical Center in Chicago reports in a recent issue of the *Journal of the American Medical Association*, that

preliminary data from 38 patients indicate that ulcers are more likely to bleed just before the full moon, and that 64 percent of the angina pectoris attacks experienced by 88 patients occurred between the full and last-quarter moon.

Some scientists suggest that part of the explanation for this phenomenon may lie in the moon's gravitational and electromagnetic field changes.



New staff member

The OSMA is pleased to announce that William E. Frye has joined the staff of the Association as Assistant Director of Government Relations. Mr. Frye was formerly with Ohio Medical Indemnity Mutual where, in the course of 21 years, he held positions as Personnel Manager, Director of Customer Relations and Director of Professional Relations. He is married and has two sons.

CME dissatisfaction

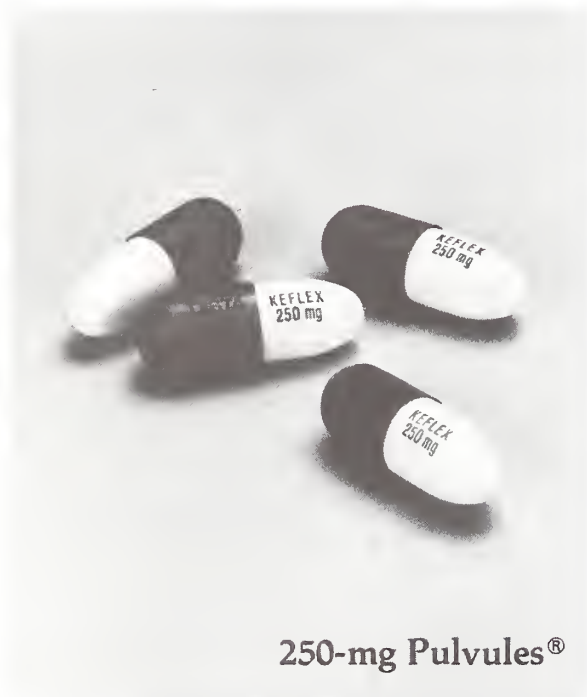
Dissatisfaction with CME conferences continues to roll in. The latest disgruntled group to speak up is emergency physicians who responded to a nationwide survey, developed by the American Institute of Primary Care Medicine (AIPCM).

"The survey results were a complete surprise," says Dr. Craig Alan Sinkinson, AIPCM President. "We expected some dissatisfaction, but nothing as universal and vehement as these findings demonstrate."

One physician stated flatly, "I've just about given up on CME conferences."

The survey found that nearly 40% of respondents consider "lack of practical or relevant information" to be the single most important deficit in the CME presentations they have attended. Close behind were complaints about the speaking ability of conference presenters and the rising cost of CME activities.

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Physician Suicide

A report from the AMA's Board of Trustees

Editor's Note: This report has been edited to meet Journal space requirements. For a complete copy of this report, please write to the OSMA, 600 S. High St., Columbus, Ohio 43215.

After an assessment of available information resources and data processing capability at the AMA, and following discussions with members of the Task Force on the Impaired Physician of the American Psychiatric Association (APA) and other knowledgeable observers, it appears that a joint AMA-APA project on physician suicide would be feasible and desirable.

The Board of Trustees will establish a Physician Suicide Project — allowing a

limited budget, so that greater resources are not committed unless and until the project's merits are demonstrated.

The pilot project will encompass physician deaths occurring in four or five states that together comprise from 15 to 20 percent of the U.S. physician population. The states selected for the pilot study will be from among those whose medical associations have Impaired Physician Committees or programs.

A description and evaluation of the project will be submitted by the Board of Trustees to the House of Delegates at the 1982 Annual Meeting.

Rationale for a Physician Suicide Project

Suicide takes an appreciable toll of the physician population.

If the objective of a project of this kind were merely to gain a more accurate count of such physician deaths, it might not justify a commitment of manpower and resources even on a limited basis. But a project, predicated on in-depth interviews of survivors, colleagues and others, promises to yield information of far greater value. It should help determine the nature and relative importance of the precursors to suicide and, by so doing, give meaningful direction to efforts aimed at prevention and treatment.

The key to obtaining accurate, relevant information is the interview, the personally conducted psychological autopsy. Not only can this type of survey yield more comprehensive and

detailed information, but is far superior to a mailed questionnaire in terms of response rate and accuracy.

From other studies and investigations, probable risk factors have been identified: eg, endogenous depression, affective disorders, chronic physical illness, alcohol and drug dependence, adverse stress in family relations and practice situations. More tenuous are those risks that relate to the make-up and specialty of the physician. For example, it is suspected that a young female physician may be in greater jeopardy for suicide than her male counterpart. Also, several studies have found that psychiatrists commit suicide at a significantly higher rate than other medical specialists, but the authors could only speculate as to the reasons.

Through the AMA Physician Suicide Project may come elucidation and explanation of such findings, and a determination of their relative

importance and possible interrelationships.

Operational Features of the Pilot Study

Suicide Identification — Four principal methods of identifying suicides and potential suicides will be utilized:

1. Selection of suicides that are labeled as such in the reports on physician deaths in AMA files. There are 25 to 30 such reports per year; this number will yield an estimated five or six definite suicides for those states involved in the pilot.

2. Selection of **possible** suicides from among total AMA death reports. This process will entail singling out physician deaths in the pilot states that met one or more criteria, such as the following:

- (a) Any death under age 30 not readily explained by organic disease.

continued on page 78

Motrin[®] vs aspirin w/codeine...

(ibuprofen)



compare the analgesic effect

A *Motrin* 400 mg dose relieved postsurgical dental pain as effectively as a combination of 650 mg aspirin and 60 mg codeine (two aspirin-with-codeine No. 3 tablets) in a study of 129 patients.

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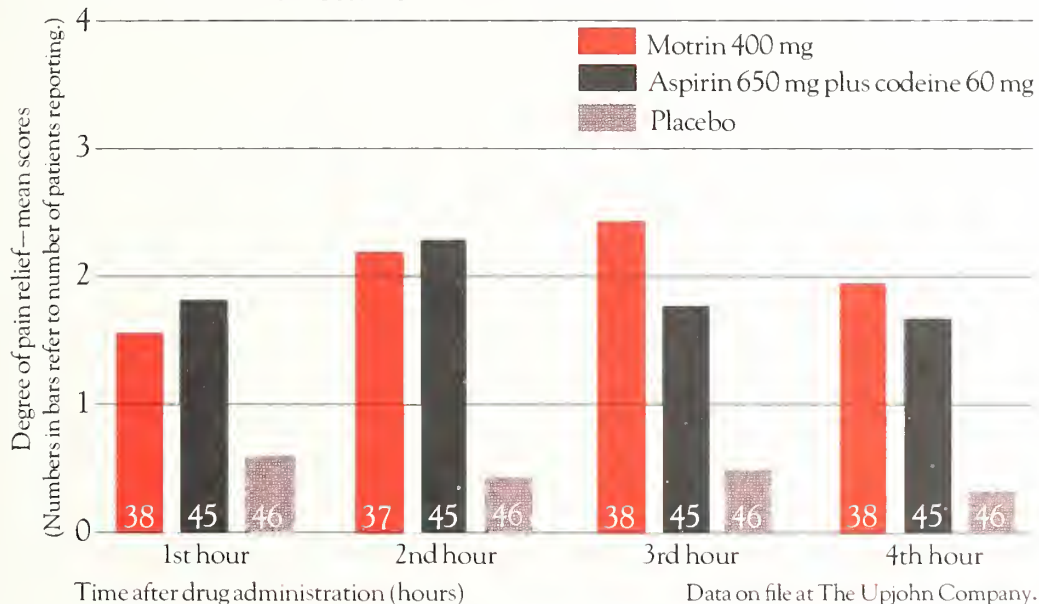
with *Motrin* being significantly more effective ($p = 0.03$) at the three-hour interval.

Active treatment was significantly more effective ($p < 0.0001$) than placebo at all time intervals.

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now proved an effective analgesic for mild to moderate pain

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Contraindications: Individuals hypersensitive to it, or with the syndrome of nasal polyps, angioedema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory agents (see WARNINGS).

Warnings: Anaphylactoid reactions have occurred in patients with aspirin hypersensitivity (see CONTRAINDICATIONS).

Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Ulceration, perforation, and bleeding may end fatally. An association has not been established. Motrin should be given under close supervision to patients with a history of upper gastrointestinal tract disease, only after consulting ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be tried. If Motrin must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

Precautions: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If these develop, discontinue Motrin and the patient should have an ophthalmologic examination, including central visual fields.

Fluid retention and edema have been associated with Motrin; use with caution in patients with a history of cardiac decompensation.

Motrin can inhibit platelet aggregation and prolong bleeding time. Use with caution in persons with intrinsic coagulation defects and those on anticoagulant therapy.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain, or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy should have therapy tapered slowly when Motrin is added.

Drug interactions. Aspirin used concomitantly may decrease Motrin blood levels. Coumarin. Bleeding has been reported in patients taking Motrin and coumarin.

Pregnancy and nursing mothers: Motrin should not be taken during pregnancy or by nursing mothers.

Adverse Reactions

Incidence greater than 1%

Gastrointestinal: The most frequent type of adverse reaction occurring with Motrin is gastrointestinal (4% to 16%). This includes nausea,* epigastric pain,* heartburn,* diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of the GI tract (bloating and flatulence). **Central Nervous System:** Dizziness,* headache, nervousness. **Dermatologic:** Rash* (including maculopapular type), pruritus. **Special Senses:** Tinnitus. **Metabolic:** Decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS).

*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: Upper GI ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** Depression, insomnia. **Dermatologic:** Vesiculobullous eruptions, urticaria, erythema multiforme. **Cardiovascular:** Congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Special Senses:** Amblyopia (see PRECAUTIONS). **Hematologic:** Leukopenia, decreased hemoglobin and hematocrit.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** Paresthesias, hallucinations, dream abnormalities. **Dermatologic:** Alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** Hemolytic anemia, thrombocytopenia, granulocytopenia, bleeding episodes. **Allergic:** Fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** Gynecomastia, hypoglycemia. **Cardiovascular:** Arrhythmias. **Renal:** Decreased creatinine clearance, polyuria, azotemia.

Overdosage: In cases of acute overdosage, the stomach should be emptied. The drug is acidic and excreted in the urine, so alkaline diuresis may be beneficial.

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AMA report (continued)

(b) Any death attributed to gunshot wounds or hunting accidents.

(c) Any death in a single-car traffic accident.

(d) Death under ambiguous circumstances, such as carbon monoxide poisoning.

About 15 to 20 such deaths per year are expected to be identified for the pilot states.

3. Selection of physician deaths from any cause that occurred in the pilot states from among the last 1,000 consecutive deaths reported to the AMA. The purpose in selecting these reports is to try to ascertain whether fatalities ascribed to various "natural causes" might in fact be attributable to self-destructive behavior. An estimated 150 to 200 deaths for the pilot states are expected.

4. Selection of definite and suspected physician suicides in the pilot states from reports of coroners and medical examiners on deaths where cause has not been recorded in AMA records. There are about 300 such deaths per year nationwide.

A fifth source of death reports might be those involving medical students in the pilot states.

When the relevant death reports are secured and screened, an interview with the next of kin will then be sought by associates of the deceased and members of the APA Task Force on the Impaired Physician. The project will be explained at this interview. In this initial approach, useful information on the psychosocial aspects of events leading to death will be sought.

The very existence of the project should create an increased awareness of the special vulnerabilities of physicians in training and in practice, and it should serve to alert those physicians who are at especially severe risk. As the project progresses, it is likely to provide an additional focus for detection and treatment programs for the impaired physician, and supplement efforts in medical education to identify and deal with high risk factors before they become lethal to practitioners of the future. **OSMA**

Breast Cancer

Selecting a Treatment

Much has been written of late on the various treatments for breast cancer. Radical mastectomy, lumpectomy, modified radical mastectomy and radiation therapy all have their proponents. This article will present the views of two physicians — one, a surgeon, the other, a radiologist. And don't miss the article "Conservative Management of Early Breast Cancer" in our Clinical and Scientific section. —

Radiation Therapy without Mastectomy

By Frank Batley, M.D.

Television interviews and magazine articles are making women more aware of the value of radiotherapy for breast cancer. This summary is written at the request of the Cancer Committee of the OSMA so that physicians may be better able to advise their patients. As is customarily said, the opinions expressed are mine and not necessarily those of the committee.

Primary treatment by radiotherapy for breast cancer has a long history. Geoffrey Keynes,¹ a British surgeon, published his results by radium implant in 1929 and again in 1937. He

stated that his five-year survival rate was similar to that of patients treated by radical surgery. Baclesse² of the Foundation Curie in Paris reported similar results in 1949, using medium voltage x-ray therapy. Although Pfahler³ of Philadelphia used radiotherapy in 1930, Vera Peters⁴ of the Princess Margaret Hospital in Toronto was the first in North America to make a substantial contribution to this method. Recently, modern opinion here has been influenced by papers from prestigious medical centers such as Harvard, Yale, Thomas

Jefferson, and the Hahnemann Hospitals, but the most scientifically impressive information is in a report from an International Breast Cancer Conference held in Monte Carlo. Four French centers had combined in a randomized controlled series comparing mastectomy with radiotherapy. The survival rates were equal.⁵

The cosmetic advantage of radiotherapy over surgery is obviously a predominant feature. Moreover, modern megavoltage machines have reduced postradiation stigmata so that

the effects are barely visible and, even when bare, are almost invisible. What are the results? In a joint report, 1980, from the above four east coast centers,⁶ the five-year survival rates of Stage I are 91% and at ten years 81%. For Stage II they reported a five-year survival rate of 77% and a ten-year survival rate of 54%. These are quite comparable to those obtained by radical and other varieties of mastectomy. Although some may say that the 15- and 20-year results may be worse than with mastectomy, the survival trends for cancer in any site do not abruptly change after five or ten years.

What of the technique? The main mass of the cancer should be excised locally. Because immediate mastectomy after local excision as a biopsy is unnecessary, permanent histology sections can be awaited and the radiotherapist's opinion obtained. Usually a sampling of lower axillary nodes is advised, since later hormonal or chemotherapeutic treatment may depend on whether these nodes are involved. Metastases to axillary nodes indicate an aggressive tumor. Dissection of these nodes will not help, since by then the disease would almost always have settled far beyond the axilla. Whether such disease produces clinical metastases is not

affected by dissection of the axillary contents.

Following primary healing of the "lumpectomy" the whole breast is irradiated with megavoltage beams carefully planned to give a homogeneous dose but little radiation

The cosmetic advantage of radiotherapy over surgery is obviously a predominant feature.

to the underlying lung. The area of the lumpectomy requires a boost dose. This can be given by a radio-iridium implant, electron beam or a radiocesium unit.

If the primary mass is large, local excision may involve a mastectomy, but in such instances, the risk of local spread of tumor at the time of surgery is so high that preoperative radiation is advisable.

This is a controversial and emotional subject, but if the radiotherapist is consulted early in the consideration of the method of treatment, there will be less embarrassment should the patient begin to question the method of treatment as an afterthought.

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Alternatives in the Treatment of Breast Cancer

By Joseph A. Bonta, M.D.

The classical radical mastectomy of Halstead was widely accepted before the turn of the century as a distinct advance in the curability of breast cancer.

Ionizing radiation (whether radium, X-ray tube, or cobalt, or other sources) became available after the turn of the century and the tug of war for the values of each has escalated continuously.

The past 30 years, the swing of the pendulum has taken us away from the classical radical mastectomy to lumpectomy, and has settled back to a middle ground — the modified radical

mastectomy, which, according to a number of reports is comparable in results to radical mastectomy.

The issues involved in this tug of war, however, are not difficult. What method of treatment will likely produce the greatest cure rate, and can we approximate that cure rate with less aggressive approaches (minimal surgery or radiation therapy) thus avoiding undesirable sequelae of treatment? These are the questions that must be answered.

The greatest challenge to the classical radical mastectomy probably came from McWhirter's study in 1949.

This study stated that McWhirter's very large series — treated with simple mastectomy plus radiation therapy — produced results comparable to radical surgery. However, the study cannot be legitimately considered a comparable study, as the survivors it lists were treated with all available palliative means.

Thereafter, however, the simple mastectomy with or without radiation therapy, gained impetus and even lumpectomy with or without radiation was revived. The failure rate of lumpectomy rather quickly extinguished that venture, so that it is

now reserved for the extremely aged or debilitated.

What then are the alternatives open to the primary physician and to the patient?

Radiation therapy can indeed cure some breast cancers, but **which** ones? Most radiation therapists propose X-ray therapy for Stage I breast cancers (tumor size less than 2 cm). Why not for the larger tumors? Because the probability of axillary and distant metastases increases with the larger breast cancers and the ability of radiation therapy to eradicate axillary metastases has remained in doubt. Most surgeons have abandoned postoperative X-ray therapy in favor of chemotherapy. The reported studies claiming results comparable to modified radical mastectomy are usually limited to Stage I cancers or are reported after a shortened follow-up period.

What are the pitfalls of accepting so-called Stage I cancers for radiation therapy? They are twofold. Many

small breast cancers are found to have axillary metastases after the pathologist's evaluation. Also, what one examiner calls 2 cm, the next may measure 1 cm or 3 cm. The pathologist's ruler measurement is precise.

The past 30 years, the swing of the pendulum has taken us away from the classical radical mastectomy to lumpectomy and has settled to a middle ground

The radiation therapists and the medical nihilists enjoy the cynicism that if axillary metastases are present then there must be metastases beyond that level and thus the value of curative surgery is in question. There

is an army of women in my practice who were found to have axillary metastases at the time of modified radical mastectomy, who would be extremely distressed to know they should have succumbed long ago.

The final decision for treatment of breast cancer, whether X-ray therapy or surgery, and whether conventional or limited surgery, must be based on the individual patient, on the established facts, and on the philosophies of the physicians and the wishes of the patient.

The place for reconstructive surgery must come **after** adequate treatment and must not compromise the need for life. **OSMA**

Frank Batley, M.D., Columbus, is a therapeutic radiologist who practices at University Hospital.

Joseph A. Bonta, M.D., Columbus, is a general surgeon who practices at Riverside Hospital.

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WARNING: This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

DESCRIPTION: IINDERIDE combines two antihypertensive agents: INDERAL (propranolol hydrochloride), a beta-adrenergic blocking agent, and hydrochlorothiazide, a thiazide diuretic-antihypertensive.

INDICATION: IINDERIDE is indicated in the management of hypertension. (See boxed warning.)

CONTRAINDICATIONS: Propranolol hydrochloride (INDERAL®): Propranolol hydrochloride is contraindicated in: 1) bronchial asthma, 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol, 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS: Propranolol hydrochloride (INDERAL®): CARDIAC FAILURE: Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) If cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn; b) If tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of propranolol therapy. Therefore, when discontinuation of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOLYCEMIA: Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

USE IN PREGNANCY: Propranolol hydrochloride (INDERAL®): The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

Hydrochlorothiazide: Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers: Thiazides appear in breast milk. If the use of the drug is deemed essential, the patient should stop nursing.

PRECAUTIONS: Propranolol hydrochloride (INDERAL®): Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncope attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause are: dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements such as foods with a high potassium content.

Any chloride deficit is generally mild, and usually does not require specific treatment except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

ADVERSE REACTIONS: Propranolol hydrochloride (INDERAL®): Cardiovascular: bradycardia; congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometric tests.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Miscellaneous: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

Hydrochlorothiazide: Gastrointestinal: anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

Central Nervous System: dizziness, vertigo, paresthesias, headache, xanthopsia.

Hematologic: leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular: orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: purpura, photosensitivity, rash, urticaria, necrotizing angitis (vasculitis, cutaneous vasculitis), fever, respiratory distress including pneumonitis, anaphylactic reactions.

Other: hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

DOSAGE AND ADMINISTRATION: The dosage must be determined by individual titration (see boxed warning).

Hydrochlorothiazide is usually given at a dose of 50 to 100 mg per day. The initial dose of propranolol is 40 mg twice daily and it may be increased gradually until optimum blood pressure control is achieved. The usual effective dose is 160 to 480 mg per day.

One to two IINDERIDE tablets twice daily can be used to administer up to 320 mg of propranolol and 100 mg of hydrochlorothiazide. For doses of propranolol greater than 320 mg, the combination products are not appropriate because their use would lead to an excessive dose of the thiazide component.

When necessary, another antihypertensive agent may be added gradually beginning with 50 percent of the usual recommended starting dose to avoid an excessive fall in blood pressure.

OVERDOSEAGE OR EXAGGERATED RESPONSE: The propranolol hydrochloride (INDERAL®) component may cause bradycardia, cardiac failure, hypotension, or bronchospasm.

The hydrochlorothiazide component can be expected to cause diuresis. Lethargy of varying degree may appear and may progress to coma within a few hours, with minimal depression of respiration and cardiovascular function, and in the absence of significant serum electrolyte changes or dehydration. The mechanism of central nervous system depression with thiazide overdosage is unknown. Gastrointestinal irritation and hypermotility can occur; temporary elevation of BUN has been reported, and serum electrolyte changes could occur, especially in patients with impairment of renal function.

TREATMENT: The following measures should be employed: **GENERAL:** If ingestion is, or may have been, recent, evacuate gastric contents taking care to prevent pulmonary aspiration. **BRADYCARDIA:** Administer atropine (0.25 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously. **CARDIAC FAILURE:** Digitalization and diuretics. **HYPOTENSION:** Vasopressors, e.g., levaterenol or epinephrine. **BRONCHOSPASM:** Administer isoproterenol and aminophylline. **STUPOR OR COMA:** Administer supportive therapy as clinically warranted. **GASTROINTESTINAL EFFECTS:** Though usually of short duration, these may require symptomatic treatment. **ABNORMALITIES IN BUN AND/OR SERUM ELECTROLYTES:** Monitor serum electrolyte levels and renal function, institute supportive measures as required individually to maintain hydration, electrolyte balance, respiration, and cardiovascular-renal function.

HOW SUPPLIED: No. 474—Each IINDERIDE® 40/25 tablet contains 40 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 476—Each IINDERIDE® 80/25 tablet contains 80-mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100.

References: 1. Kaplan, N. M. Beta-blockade in the treatment of mild to moderate hypertension, in Braunwald, E. (ed.) Beta-Adrenergic Blockade, A New Era in Cardiovascular Medicine, Amsterdam, Excerpta Medica, 1978, pp. 253-263. 2. Veterans Administration Cooperative Study Group on Antihypertensive Agents. J. A. M. A. 237: 2303 (May 23) 1977.

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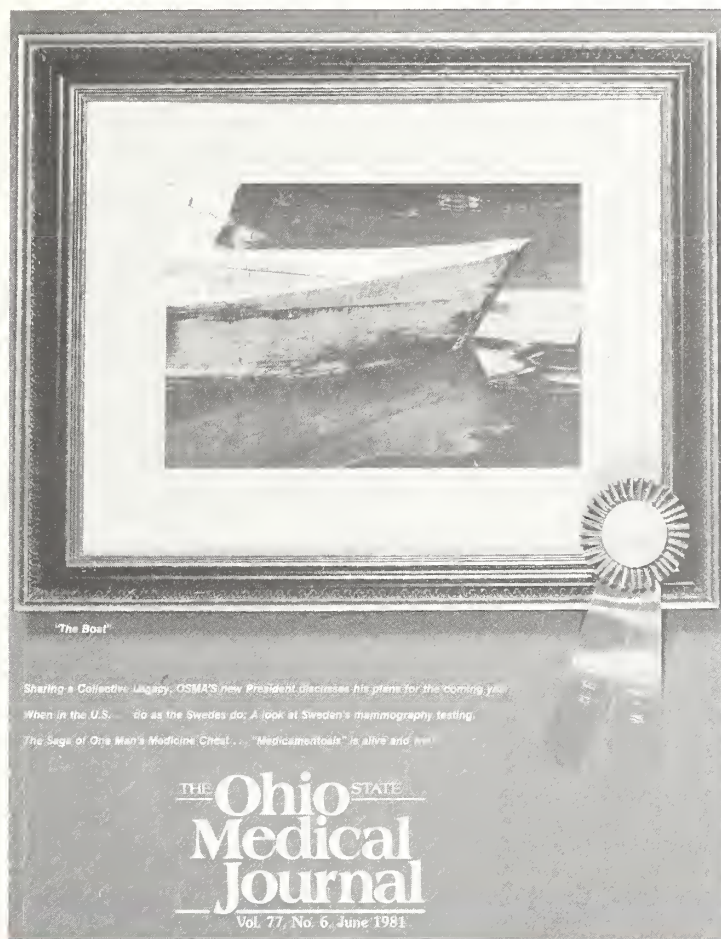
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The 1982

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Photographic Exhibit



The Ohio State Medical Journal is sponsoring its fifth annual photographic exhibit and competition. The 1982 competition is open to both physicians and spouses. Persons submitting winning entries will receive awards at the 1982 Annual Meeting, Dayton, where the entries will be displayed.

Photographs may be entered in two divisions: Black and White, and Color. Each division has two categories: General and Scientific.

Entries must be in print form (8" x 10" or 11" x 14") in size) and mounted on print board, or otherwise for ease of display on a peg board. Photographs placed under glass will not be accepted. All entries submitted must be previously unpublished, and right to publish the photograph must be given to the Journal at the time the photograph is entered in the exhibit.

An OSMA member or spouse may submit as many entries as he/she wishes. Each photo must be accompanied by an entry form and a \$10.00 entry fee. If mailed, please be certain photograph is securely wrapped to avoid possible damage.

ENTRY FORM

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Telephone _____

Information about photograph:

(provide as much as possible)

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Speed _____ Aperture _____

Subject _____ Film Type _____

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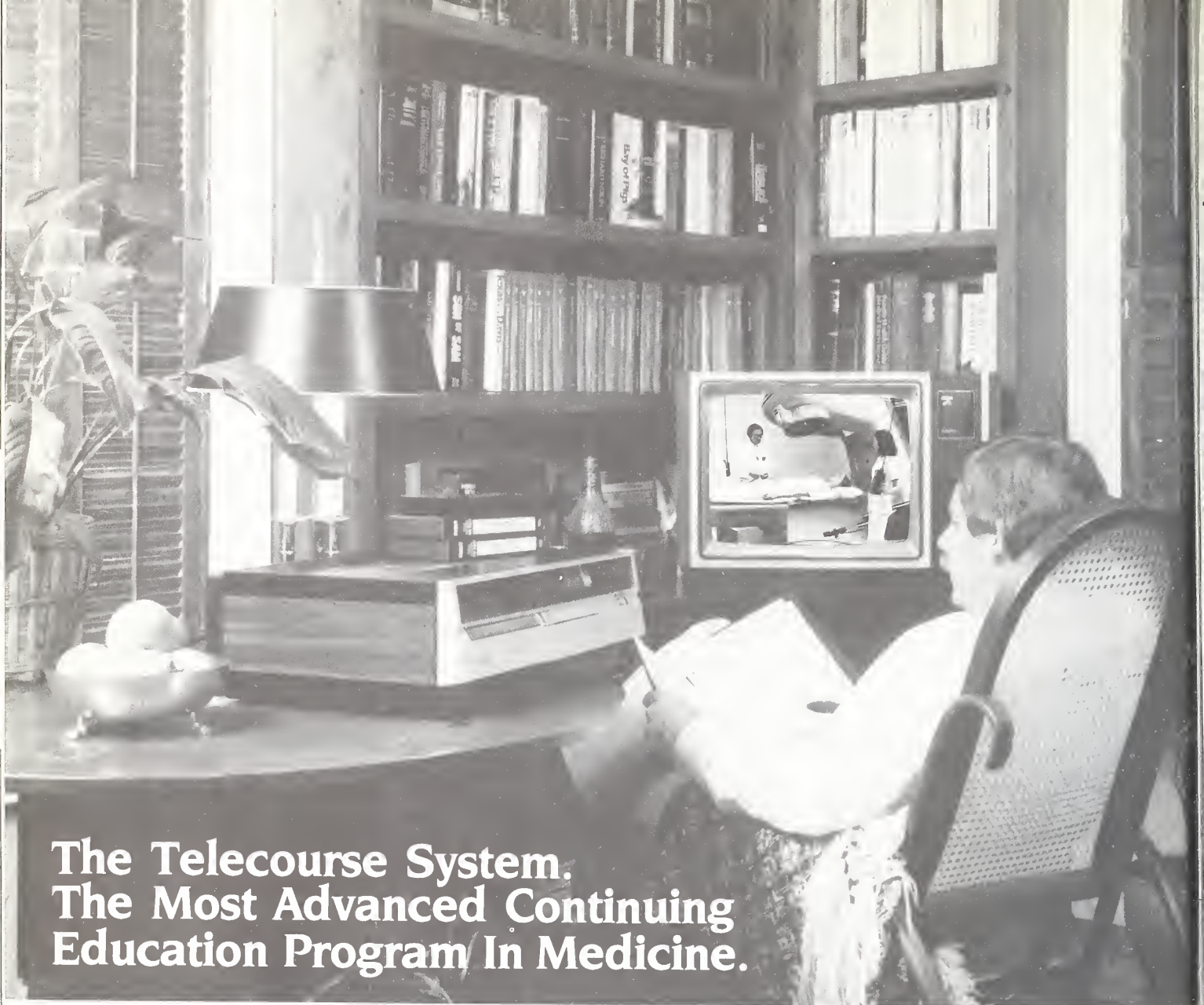
☐ Professional

☐ Self

Mail or hand carry the photograph, entry form and \$10 entry fee (make checks payable to The Ohio State Medical Journal) to: The Ohio State Medical Journal Photographic Exhibit, 600 S. High Street, Columbus, Ohio 43215. All entries must be received no later than March 26, 1982.

I give the *Journal* publication rights to this photograph. I certify that this photograph has not been published previously and that I will not submit it for publication elsewhere pending the judging of the photographic exhibit. Also, I certify that any person(s) pictured have given me authorization to allow publication of his/her photograph. I also understand that if my photograph is selected for a Journal cover, it may be cropped to meet printing specifications.

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The AMA interim business report

Business in Vegas

By Oscar Clarke, M.D. and Stewart B. Dunsker, M.D.

This report covers some of the important issues voted on by the Ohio Delegation at the 1981 Interim Business meeting of the American Medical Association in Las Vegas, Nevada, December 6-9, 1981.

There were 73 reports and 53 resolutions considered by the AMA House of Delegates. Three of the resolutions were introduced by the Ohio Delegation.

Hospital Malpractice

The first Ohio resolution on Hospital Malpractice was adopted by the AMA House of Delegates after changing the name of the resolution to Subrogation by Hospitals. The resolution urges the AMA to encourage hospitals to enter only into professional liability insurance contracts that require the carrier to obtain the hospital's consent before initiating legal actions against a physician in the name of the hospital. It was generally accepted that if the intent of the resolution could be implemented, it would strengthen relationships between medical staffs and hospitals.

Request for Clarification of JCAH Medical Staff Standard I

The second Ohio resolution was

adopted by the AMA House of Delegates and urges the AMA to request JCAH clarification of the standard governing responsibility for dental patients who have medical problems on admission or which arise during hospitalization.

Specialty Society Representation

The third resolution introduced by Ohio was referred to the Board of Trustees along with four other resolutions on the same subject for a joint report from the Board of Trustees, the Council on Long Range Planning and Development and the Council on Constitution and Bylaws. A report is to be submitted to the House of Delegates at the 1982 Annual Meeting. The Ohio resolution asked that no additional societies be granted a seat in the AMA House of Delegates unless it can be demonstrated that the particular group of physicians is inadequately represented by existing groups or specialty societies.

The Ohio Delegation supported this action.

Two resolutions introduced by the Ohio Delegation at the 1981 AMA Annual Meeting resulted in two reports from the Board of Trustees at

the 1981 Interim Meeting. Action on the reports is as follows:

Hospital Admission Histories and Physicals

The AMA House of Delegates adopted an amendment to the Board of Trustees report stating that, "It is the position of the American Medical Association that the best interests of hospitalized patients are served when admission history and physical examinations are performed by a physician, recognizing that portions of the histories and physical examinations may be delegated by the physician to others whose credentials are accepted by the medical staff."

The Right of a Hospitalized Patient to Choose His Attending or Consulting Physician

The AMA House of Delegates adopted a Board of Trustees report that stated, among other things, that contracts between hospitals and physicians for exclusive medical services generally have been declared to be valid and that the adoption and implementation of the Ohio resolution on this subject (A-81) could be construed as interference and restraint

upon the freedom of physicians and hospitals to contract.

The Ohio Delegation voted against the adoption of this Board of Trustees Report.

Tax Credit for Physicians Treating Medicaid Patients

All matters relating to this subject were referred to the Board of Trustees for study and to report findings and recommendations at the 1982 Annual Meeting. The referred material includes a Council on Medical Service report that discusses the problems and probable public reaction to efforts to obtain tax credits or deductions for the differential between Medicaid payments and the treating physician's usual charges.

The referred resolution calls on the AMA to seek changes in tax laws to permit physicians to treat the value of services to indigent patients as tax deductions or credits rather than billing government agencies for these services.

The Reference Committee agreed that the concept of tax credits for care of the poor is attractive, but implementation could engender more new problems than it would provide solutions.

The Ohio Delegation was in unanimous support of this referral.

Medical Education Essentials for the Accreditation of Sponsors of Continuing Medical Education

The AMA House of Delegates adopted a Council on Medical Education report regarding seven essentials for the accreditation of services of continuing medical education. The seven essentials are as follows:

1. The sponsor shall have a written statement of its continuing medical education mission, formally approved by its governing body.
2. The sponsor shall have established procedures for identifying and analyzing continuing medical educational needs and interests of prospective participants.
3. The sponsor shall have explicit objectives for each CME activity.
4. The sponsor shall design and implement educational activities consistent in content and method with

the stated objectives.

5. The sponsor shall evaluate the effectiveness of its overall continuing medical education program and component activities and use this information in its CME planning.

6. The sponsor shall provide evidence that management procedures and other necessary resources are available and effectively used to fulfill its continuing medical education mission.

7. The sponsor shall accept responsibility that the essentials are met by educational activities which it jointly sponsors with nonaccredited entities.

The Ohio Delegation was in unanimous support of adoption of this report.

Periodic Medical Evaluation - Review and Recommendations

The AMA House of Delegates referred back to the Council on Scientific Affairs a report that recommends, among other things: (1) that an annual visit to a physician by a person over age 45 serves "as a convenient reference point for preventive services"; (2) that testing of individuals and population groups should be pursued only when adequate treatment and follow-up can be arranged; and (3) that physicians need to further improve their skills in fostering patients' good lifestyles, and in dealing with long-recognized problems such as hypertension, obesity, anxiety, depression, and the excessive use of alcohol and drugs.

The Ohio Delegation supported referral.

Cutback in Funding For Physician Peer Review Under Medicare

The AMA House of Delegates did not adopt a resolution that asked the AMA to request reconsideration by the Health Care Financing Administration of its cutback in funding for carrier and intermediary physician peer review under Medicare. The reference committee believed that adoption of this Resolution would be in direct contradiction to present Association policy calling for elimination of all government-directed peer review programs, and that present policy should be retained so as to allow continuation and expansion of

voluntary, professionally directed peer review.

The Ohio Delegation unanimously supported this action.

Physician and Public Education on the Medical Consequences of Thermonuclear Warfare

The AMA House of Delegates adopted a Board of Trustees report stating that the AMA inform the President and Congress of the medical consequences of nuclear war; prepare informational materials to educate physicians and the public on the medical consequences of nuclear war; and cooperate with authorities in dealing with matters having to do with health and medical care in the event of national emergencies.

The Ohio Delegation was in unanimous support of adoption of this policy.

There are many excellent reports presented to the House of Delegates at each meeting, covering a wide range of subjects that are of interest to physicians. These reports, prepared by AMA councils, committees and staff, contain a wealth of information.

A listing, by title, of some of the reports follows. If you would like a copy of any or all of these reports, please contact the OSMA office.

1. Health Manpower
2. Look-Alike Drugs
3. Surplus of Physicians
4. Interim Report on Child Molestation
5. HMO Competition Feasibility Study
6. Financing a Medical Education
7. Charging Interest on Overdue Accounts; Finance Charges
8. Education of Limited License Practitioners
9. Principles for Voluntary Medical Peer Review, An Interim Report
10. Competition in Health Care
11. Definition of Competition
12. Genetic Counseling and Prevention of Birth Defects
13. Health Care Needs of an Underserved Population
14. Prescription of Tranquilizers and Antidepressants for Women **OSMA**

Oscar Clarke, M.D., Gallipolis, is Chairman of the OSMA Delegation to the AMA. Stewart B. Dunsker, M.D., Cincinnati, is OSMA President.

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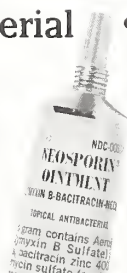
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INDICATIONS: *Therapeutically* (as an adjunct to systemic therapy when indicated), for bacterial infections, primary or secondary, due to susceptible organisms, as in • infected wounds, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, erythema, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically* the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and aid wound healing.

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neo-



mycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching, it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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The New Illiterates

By Karen S. Edwards

Somehow, it doesn't add up. While millions of American adults don running suits, dine at salad bars and ask intelligent questions of their family physicians, an ever-increasing number of their children are abusing their bodies with cigarettes, drugs, alcohol and promiscuous sexual activity. Where does the problem lie? Is it simply adolescent (and, in some cases, preadolescent rebellion) or could there be some other reason for this diverse variation in lifestyles?

Charles McMullen, M.D., a Loudonville family practitioner and Chairman of the Ohio State Medical Association's (OSMA) Committee on School Health, is one physician who is

of their own bodies," he says.

And it's small wonder. There's no question that health education has always received something of a short shrift in Ohio schools. At the kindergarten level, health must compete with seven other subjects in an "up-for-grabs" instruction time. Current requirements can be met if only 30 seconds of health education are taught per week — and there's not much improvement at the grade school level. By the time a student reaches the fifth grade, health education is one of four subjects that must somehow fit into an allotted 30 percent of the school week.

Of course, health's early back seat to

At the kindergarten level, health must compete with seven other subjects in an "up-for-grabs" instruction time.

pointing to the public schools as being, at least in part, responsible for the problem.

"Children are growing up illiterate

the "three Rs" may be somewhat understandable — but this same "minimum standard" prevails at the high school level. Students need only



The Revisions Committee listens to testimony presented by physicians who wish to increase the level of health education in Ohio Schools (photo courtesy of Louis J.R. Goorey, M.D.)

one half unit of health education to fulfill graduation requirements. That's barely enough to teach basic anatomy.

Still, it wasn't until this past year that Dr. McMullen and members of his committee realized just how low health education had sunk on Ohio schools' priority list.

Last year, after 13 years, the Ohio Board of Education decided to revise the minimum standards for Ohio schools. A revision committee was formed which drew up a new set of minimum standards. They recommended, for example, that both music and art be raised a half unit of credit needed for graduation to a full unit of credit. But the entire subject of health education remained untouched.

That's when the OSMA School Health Committee, along with other physician-oriented groups such as the Ohio Chapter of American Pediatrics, represented by Elizabeth Aplin, M.D., and Leonard Rome, M.D., and the State Planning Committee on Health Education in Ohio, decided to get involved.

"We sent out letters requesting physicians to testify at hearings of the Revision Committee and we got a

tremendous response," says Dr. McMullen.

At least ten physicians turned out at the initial hearings held throughout the state during January and February — and their concerned words have been successful, thus far, in blocking acceptance of the revisions as they presently stand. Other hearings will be held, and the Committee is hopeful that health education can still be strengthened before the revisions are accepted by the Board of Education.

"I'm not so naive that I believe by changing the curriculum, the students will gain instant knowledge," says Roy Geduldig, M.D., Dover, in his testimony before the Revision Committee last February. "On the other hand, the minimal attention paid to Health Education in the curriculum leads the students to believe health isn't of any great importance. They tend to slough it off."

The OSMA is urging that the draft be amended to include specific allotments of classroom time for health education at the K through grade 12 level.

"We suggest 60 minutes per week in kindergarten and 120 minutes per

week in grades 1-8. In addition, we recommend that a full unit of credit be required at the grade 9-12 level in order to meet requirements for graduation," Dr. McMullen says.

This recent push by the OSMA for a comprehensive health education curriculum is nothing new. Since the adoption of a resolution by the House of Delegates in 1974, the OSMA, through its School Health Committee, and through its membership on the influential State Planning Committee for Health Education in Ohio, have extended every effort toward improving health education in the schools. And, in many respects, they've been successful.

"There was a time," recalls Louis Goorey, M.D., a Columbus pediatrician who not only serves as a member of OSMA's School Health Committee, but as a member of State Planning Committee as well, "when physical and health education were combined in the schools, and someone with no health education training would be responsible for teaching health."

"The minimal attention paid to Health Education in the curriculum leads the students to believe health isn't of any great importance."

Thanks largely to physician effort, this situation was reversed by the Ohio Legislature. Now the two subjects are treated separately, and a mandate has ensured that health courses are taught by certified health instructors.

"But you have to understand this is not always a popular way to get things done," says Dr. Goorey. "The school districts jealously guard their own areas, and they don't like being told what to do by the State."

For example, when the issue was

raised of whether or not to move vending machines (selling what health-conscious consumers now classify as "junk food") away from the schools' cafeterias, school districts seemed to go into an uproar. After much ballyhoo, the Ohio Legislature decided to let each school district decide for itself where its vending machines would be placed.

"...One of the most important items to include in a course is to teach youngsters how to manage stress."

"But the point is," says Nancy Goorey, D.D.S., who serves with her husband, Dr. Louis Goorey, on the State Planning Committee, "if children were receiving proper health education, such a question as 'where to place vending machines' would never be raised. The children would have the ability to make such informed nutritional choices for themselves."

Dr. Nancy Goorey, along with her husband and other members of OSMA's School Health Committee, (as well as the State Planning Committee) envision an ideal structure for a health education course which should be flexible enough to meet each school district's needs.

"The first thing we'd like to do is change the name of the course. 'Health education' turns the kids off before they even sit down," she says. "Something like 'Lifestyle' would be more appropriate, anyway, for the kind of curriculum we envision."

"Teaching children how to take care of their health would be the primary focus," says Dr. Nancy Goorey, and as Dr. Louis Goorey adds, "one can never start too early."

Kindergarten students would receive information on the right kinds of food to eat, how to brush their teeth properly, as well as the importance of immunization. Other levels would receive such information as what is

proper exercise — and how to do it safely.

"I think one of the most important items to include in such a course," says Dr. Nancy Goorey, "is to teach youngsters how to manage stress. Adolescent years are extremely stressful years. That's why so many of them take up smoking or turn to alcohol and drugs. However, if they had been taught from an early age how to handle stress, they might find better ways to cope with their tensions."

The logic is good, and by no means is the Ohio Board of Education turning totally deaf ears.

As Franklin B. Walter, Superintendent of Public Instruction for the Ohio Department of Education has noted, "The task of educating the youth of Ohio to enjoy a lifetime of optimal health is awesome."

He and others on the School Board are working closely with the State Planning Committee and the OSMA's School Health Committee to encourage a more healthful future for today's youth through a cooperative relationship between home, school, and community.

"There is little chance of successful state legislation to mandate the concept of a K-12 comprehensive health education curriculum," notes OSMA Associate Executive Director Robert Clinger who staffs the Committee on School Health. "However, it is felt that strengthening the minimum standards — will represent a major step in the right direction."

Should the Ohio Board of Education agree, and expand its health education program to reach out to more youngsters, it's possible that the current trend of healthy American adults may last longer than we think.

There is still much to do in this area. Physicians are encouraged to participate on their local school boards and to follow closely the progress of health education in their own districts. If you are interested in this project, or would like to lend some assistance or support, please contact Robert Clinger, The Ohio State Medical Association, 600 S. High St., Columbus, Ohio 43215, 614-228-6971. OSMA



Special Cases

As if OSMA members weren't busy enough, testifying in attempts to raise the minimum standards of health education in Ohio, there are some OSMA members who are following up on yet another project connected with Ohio schools.

This is the recent effort made by the OSMA and its physician representatives on the Joint Advisory Committee on Special Education; the Ohio Chapter-American Academy of Pediatrics (AAP); and the American Medical Association's (AMA) House of Delegates to clarify medicine's role in the federal government's "Education for All Handicapped Children Act."

The Act, passed by Congress in 1975, mandates that appropriate public education be provided to all handicapped children at public expense. However, no mention has ever been made about the importance of accurate medical diagnosis in the identification and placement of handicapped children in the schools.

Physicians representing OSMA on the Joint Advisory Committee on Special Education are adamant about insisting premedical evaluations, plus medical consultation (on a continuing basis when necessary) be mandatory for children being considered for enrollment in special education programs in Ohio. Many are testifying to this effect before the State Board of Education's hearing on revision of minimum standards for special education in Ohio.

Meanwhile, nationwide the AMA's House of Delegates has adopted a proposal, first made by the AAP, to develop a nationwide education program for physicians and educators, entitled, "New Direction in Care for the Handicapped Child." The program is designed to aid physicians and educators in developing coordinated procedures to insure proper medical input into development of handicapped students' individual educational plans. **OSMA**

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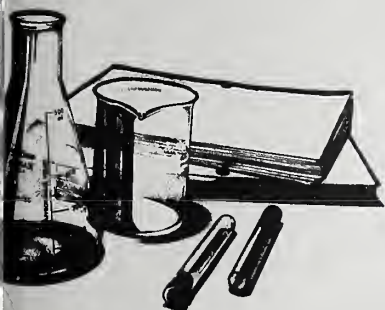
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*Incidence 3% to 9%.

Incidence less than 1 in 100

Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme. **Special Senses:** amblyopia (see PRECAUTIONS). **Hematologic:** leukopenia, decreased hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure.

Causal relationship unknown

Gastrointestinal: Hepatitis, jaundice, abnormal liver function. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities. **Dermatologic:** alopecia, Stevens-Johnson syndrome. **Special Senses:** Conjunctivitis, diplopia, optic neuritis. **Hematologic:** hemolytic anemia, thrombocytopenia, granulocytopenia bleeding episodes. **Allergic:** fever, serum sickness, lupus erythematosus syndrome. **Endocrine:** gynecomastia, hypoglycemia. **Cardiovascular:** arrhythmias (Sinus tachycardia, bradycardia, and palpitations). **Renal:** decreased creatinine clearance, polyuria, azotemia.

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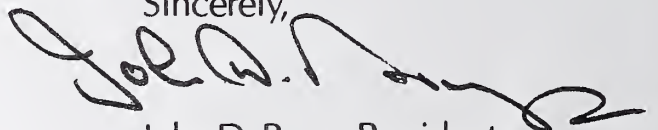
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Medicine on the High Seas



By Gordon S. Walbroehl, M.D.

The vision most of us have of a ship's doctor has been molded more by **Love Boat** than by reality. However, during a recent cruise on the Queen Elizabeth II, I had the fortunate (or unfortunate) chance to have my illusion shattered. The ship's doctor, Dr. Alan Kirwin, MRCS, LRCP, DA, was kind enough to invite me to his surgery for a look around and a chance to interview him. Unlike the carefree image of a ship's doctor, as projected on television, Alan had but a few moments to spare. Though he didn't rush me, I noticed that when I left there were six or eight patients waiting for him in his surgery.

Alan arrived at his job in a rather roundabout way. After six years in the Royal Navy he had worked as a general practitioner in Ascot, England for a year and a half. After a divorce he went to Saudi Arabia for two years as a company physician. He signed on the QE II a year ago, initially just to

give it a try. He has been with the ship ever since.

When asked about the favorable aspects of his job, Alan comments on the travel and the opportunity to meet people as being the two he would rate most highly — but he also enjoys the

received since leaving the National Health Service.

However, some of these very same items are included in the area of drawbacks. For example, an unstable population and the lack of clinical and laboratory support facilities are a

When asked about the favorable aspects of his job, he comments on the variety of medical problems, as well as the challenge of handling them by himself, in the middle of the Atlantic.

variety of medical problems he sees as well as the challenge of handling them by himself — in the middle of the Atlantic. He praises the staff with whom he works and comments favorably on the better pay he has

constant problem. He also mentioned his frustration in not receiving a follow-up on the patients who are referred to land-based physicians. He and his colleagues have often suspected certain diagnoses, yet could



Medicine on the High Seas

never find out whether their suspicions were correct or not.

I was also able to tour the facilities on board and found them quite extensive — an operating suite, one ICU-type bed with oxygen and monitors, several three- and four-bed wards and two isolation rooms. In addition, there was an outpatient office and waiting room, a physical therapy room and a dentist's office.

A team of five physicians covers the Cunard passenger ships. On the QE II they work in pairs, but on the smaller ships there usually is only one physician. The schedule is two months on and one month off. Like Alan, most physicians are in their 30s and 40s and plan to do this job for about two to five years before moving on. Of the five physicians, all male, two have

never married, two are divorced and one is married. When I inquired about family benefits, Alan stated one's immediate family could spend up to three months per year on board the ship on a space-available basis.

The protocol demands do not seem to be that great. The two physicians split attendance at the passenger tables — one in first class and one in tourist. They are expected to eat at least one meal per day with the passengers, although in rough weather, passenger illness often causes them to miss several days in a row. In addition, there is required attendance at the captain's parties for both classes, as well as at a small cocktail party given for those passengers who sit at the two doctors' dining room tables.

Inspection duty includes checking

the galleys and a few other public health matters. On a large ship such as the QE II there is a public health officer, but on the smaller vessels the

Physicians are expected to eat at least one meal per day with the passengers — although in rough weather, passenger illness may cause them to miss several days in a row.

physician must perform this job.

As we were closing the interview I asked Alan to give me his opinion on the National Health Service. He echoed the comments of others with whom I had spoken: The acute care was excellent — all could be treated regardless of financial status. The major problem arose with chronic problems as "Sign on a list and wait" seems to be the usual course for hernia repairs, hemorrhoidectomies, varicose vein procedures, etc. Geriatric care in particular was plagued with long waiting lists.

Overall, Alan left me with a positive attitude toward his job — despite the busy schedule and the apparent lack of free time. I thought it might be fun to sign on for a month or two, but I don't know if I could do it full time. Like anyplace else, it looks like a great place to visit. . .but could I really live there? **OSMA**

Gordon S. Walbroehl, M.D., Dayton, is Assistant Professor, Department of Family Practice, Wright State University



Dr. Alan Kirwin and his nurse await patients in the medical facilities aboard the Queen Elizabeth II

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References: 1. Shaw S, Lieber CS. Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease*, op. cit., p. 781. 3. Shils ME, Randall HT. Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, op. cit., pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med* 89 (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.

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THE MULTIVITAMIN/MINERAL FORMULATION

OMIM's

Participating Agreements

A personal decision

Ohio Medical Indemnity Mutual, Inc. (Blue Shield, Worthington) has announced its development of, and commitment to, a participation agreement program which it intends to start promoting in the near future (possibly by May of 1982).

The Officers and Councilors of the Association, are being asked by the members and other providers questions about the details of the OMIM program. It is understood at this time that OMIM has formulated a strategy for marketing the participating agreement to physicians and other providers and as a part of that marketing strategy representatives of OMIM will soon be contacting Ohio physicians personally.

The OMIM participating agreement program will probably be marketed and promoted as a major element in an overall "cost containment" initiative which the Cost Containment Committee of the OMIM Board directed management to research and develop.

Participating agreement programs are neither new nor novel. Many Blue Shield plans have such programs (we believe only 12 of the 69 Blue Shield plans nationally do not have such programs). Also, Medicaid is a mandatory participating agreement program if physicians are to be compensated for their services.

Medicare is a voluntary program with assignment of benefits being determined on a case-by-case basis. Lastly, the laws of at least one state (Massachusetts) provide that the Blue Shield plan institute a participating agreement program.

The essential elements generally found in a participating agreement are:

1. The physician accepts as payment in full the reimbursement determination of the plan.
2. Physicians cannot bill patients directly for any part of their fees.
3. The reimbursement determinations by the plan remain constant for a set period of time (usually 12 months).

determination individually (or in conjunction with his partners or other practice group members) as to whether or not to participate. There will be no option on a patient basis. It will be all or nothing.

2. Reimbursement by OMIM must be accepted by participating physicians as payment in full.

3. There would **not** be a differential in reimbursement levels, ie, participating and nonparticipating physicians would be entitled to the same level of payment.

4. Reimbursement would be determined on the basis of a modified "usual and customary" formula.

OMIM has formulated a strategy for marketing the participating agreement to physicians and other providers

4. There is no case-by-case participation. Participation is either all or none.

OMIM's participating agreement program would, as we understand it, have the following characteristics:

1. It would be voluntary, ie, each physician would make the

5. There would be a 30-day cancellation provision for either party.

6. Lists of participating physicians would not be developed by OMIM, although there are other participating agreement programs nationally where such lists have been developed and published.

As noted above, the marketing strategy of OMIM will probably involve emphasis during their personal contacts with physicians on the economic incentives and advantages of the program (eg, the argument that cash flow to physicians will be increased because payments will be made expeditiously and directly to participating physicians). However, OMIM will undoubtedly **not** focus upon the disincentives and disadvantages to the program which many physicians will quite readily perceive.

Many physicians perceive participating agreement programs to contain certain undesirable characteristics such as:

1. The loss of freedom by physicians in dealing directly with their patients on fee and reimbursement matters.
2. The "lock-in" to a reimbursement level for a fixed period of time.
3. The "lock-out" of certain reimbursement procedures (ie, patients would not have the option of

assigning their benefit payments to nonparticipating physicians).

4. Claims handling for nonparticipating physicians might be inferior in terms of timeliness of service, etc.

Our legal counsel, Porter, Wright, Morris & Arthur, has, as you know, cautioned us that the decision whether or not to participate in the OMIM program should be made **individually** by each physician and that OSMA officers, councilors, and staff and the officers and staff of its component medical societies should be careful to avoid even the appearance of making or suggesting to OSMA members, nonmember physicians or other providers threats of retaliation or sanctions of any kind if they sign or refuse to sign the participation agreements which OMIM intends to offer them in the near future. Nonetheless, it is important that our members and other physician providers be aware of all aspects of the participation agreement issue. **OSMA**

A picture's worth a thousand . . . sedatives?

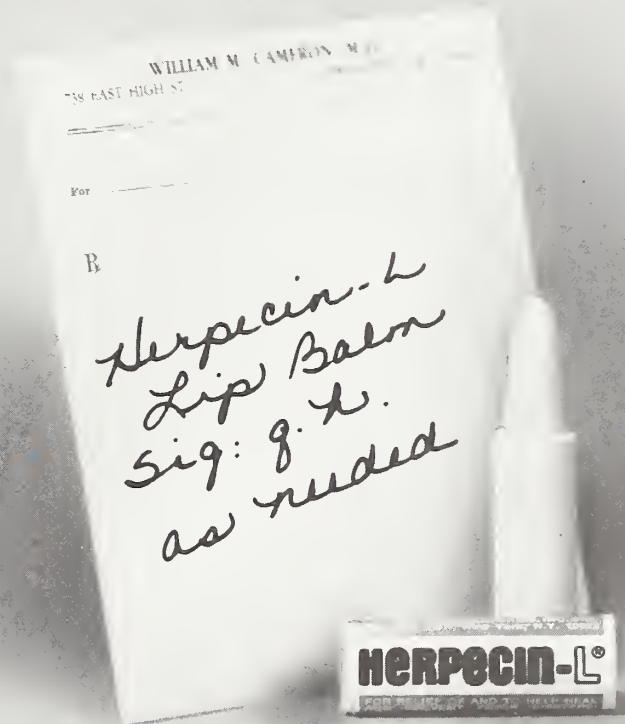
A West Coast sociologist has produced a video program which he says helps to soothe and calm patients — particularly the one awaiting surgery.

Based on a therapy he has entitled "Alphagenics" (referring to the Alpha waves of the brain), he simply shows patients relaxing scenes of outdoor beauty, accompanied by a soothing and reassuring voice — orchestrated into an ascending effort to put the patient at ease.

The program, says its creator, is meant to serve as "a passive, volitional approach to mind and body influence — which means you do nothing, just allow the suggestion and the video scene to be experienced in your body."

Several hospitals and clinics are currently adapting it to produce a calming effect on their nervous patients.

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Containing Costs — Voluntarily

By Carol Wright Mullinax

If rising health care cost, like the weather, strikes you as a subject that is all talk and no action, the Ohio Voluntary Effort (OVE) has a message for you. Starting next month there will be something you can do.

In March, the Ohio Voluntary Effort will launch a campaign aimed at making patients more aware of their role in rising health care costs. Herman I. Abromowitz, M.D., Dayton, the Ohio State Medical Association's (OSMA) physician representative serves as cochairman of the OVE, along with Donald L.



Herman I. Abromowitz, M.D. is serving as cochairman of the Ohio Voluntary Effort

Turner, D.O., of the Ohio Osteopathic Association and Walter A. Mischley of the Ohio Hospital Association. The Auxiliaries of each of these Associations, including Mrs. Shirley Davies, President of the OSMA Auxiliary, are also involved. Dr. Abromowitz calls this campaign "the long-awaited result of several years of effort" on the part of constituent members of the OVE — health care providers, payers, business, consumers, government and others.

Included in the consumer awareness campaign plan are a brochure entitled "A Tool Kit to Cut Health Care Costs," radio and television public service announcements and a speaker's bureau whose job will be to carry the message to the public. The brochure details some of the reasons behind rising health costs and offers tips on how to cut those costs. It gives some very good tips on how the average person, with very little effort, can help reduce health costs," Dr. Abromowitz says, adding that, as a physician, he is pleased that the brochure stresses the

importance of a healthy lifestyle in lowering costs.

OVE plans to distribute the brochures which are contained in a free-standing placard, by placing them in hospitals throughout the state. But Dr. Abromowitz stresses that the role of the physician in OVE's campaign cannot be overlooked. "I would like for every physician in the state to stock his office with those brochures," Dr. Abromowitz says. "It is a perfect way for a physician to let his patients know that he is concerned about rising costs."

Dr. Abromowitz is convinced that an enlightened health care consumer can add to the efforts already being made by physicians, hospitals and third-party payers and accomplish the goal of the OVE — containing health care costs. He says, "Working together we can help to contain rising costs voluntarily, without government regulation." **OSMA**

Carol Wright Mullinax is Associate Director, Department of Communications

OVE Brochures

Please send me _____ brochures and a stand for my office. (Mail this coupon to OSMA, 600 S. High St., Cols., Ohio 43215)

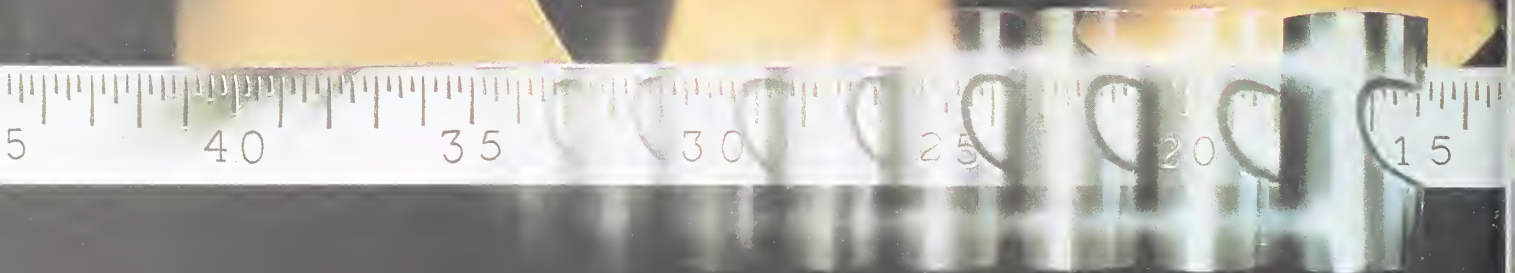
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(Citations provided on request.)

Comparison of Anorectics

	Agent	Amine Classification	Half-life ^a	Variety of Dosage Form	Degree of CNS Effects
Low Abuse Potential	Diethylpropion	Tertiary	4-6 hrs.	25 mg tablet, 75 mg controlled-release tablet	Mild euphoria, mild stimulation
	Mazindol	Nonphenylethyl-amine	33-55 hrs.	1 & 2 mg tablet	Mild euphoria, mild stimulation
	Fenfluramine	Secondary	10-30 hrs.	20 mg tablet	Moderate sedation (mild to moderate depression, a side effect, is also sometimes designated as a CNS effect)
	Phentermine	Primary	19-24 hrs.	8 & 37.5 mg tablet, 8, 15 & 30 mg capsule 15 & 30 mg capsule (resin complex) 15 & 30 mg timed release capsule	Mild euphoria, moderate stimulation
High Abuse Potential	Phenmetrazine	Secondary	7-9 hrs.	25 mg tablet, 50 & 75 mg prolonged action tablet	Marked euphoria, marked stimulation
	Amphetamine	Primary	10-30 hrs.	Various	Marked euphoria, marked stimulation

^aDelayed release characteristics of certain dosage forms must also be taken into account.

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(diethylpropion hydrochloride USP)

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Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. When central nervous system active agents are used, consideration must always be given to the possibility of adverse interactions with alcohol. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychological dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdose. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride) One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release. One 75 mg. tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSEAGE: Manifestations of acute overdose include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine[®]) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdose.

Product Information as of June, 1980

Reference: 1. Abramson R, Garg M, Cioffari A, and Rotman PA. An Evaluation of Behavioral Techniques Reinforced with an Anorectic Drug in a Double-Blind Weight Loss Study. J Clin Psych 41:234-237, 1980.

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15 states still harbor disease

Patient's travel history could be important in diagnosing plague

A teenage patient from New Mexico was recently hospitalized in Nebraska where she was treated for lethargy, right groin pain, nausea and vomiting and released.

As far as the Nebraska hospital was concerned, the case would have been closed — had they not been notified that a member of the teenager's household in New Mexico had contacted the plague.

Although rare, there are 15 western states — all west of the 100th meridian (an imaginary line, drawn from approximately the middle of Texas up through the middle of North Dakota) which have documented reservoirs of plague in their wild rodent population. Persons visiting or living in known plague areas may acquire the disease through the bite of a plague-infected flea or through exposure to infected animal tissue, which can happen in the handling of animals, or even in the

skinning of dead animals.

Through the efforts of health officials in a number of states, the Nebraska State Police were able to intercept the teenager's car and escort her back to the hospital, where the appropriate therapy was begun.

According to Jonathan M. Mann, M.D., of the New Mexico Health and Environment Department in Santa Fe, this incident illustrates the problems that can arise when plague victims travel to states where plague does not naturally occur, and where the disease may not be considered in diagnosing illness — thereby creating potential hazards to patients and to persons having contact with them. Dr. Mann advises physicians to obtain a travel history from patients who have symptoms resembling those associated with plague, and to immediately contact their local or state health department.



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Ohio State Medical Association

1982 Budget Allocation

Account:	01	02	03	04
	Admin.	Educ. & C.M.E.	Health Education	Field Service
Furniture and Equipment	\$ 2,000.00	\$ 2,450.00	\$ 100.00	\$ 1,000.00
Term Debt: Current	1,682.30	2,686.66	1,104.80	1,632.09
Journal: Publication Cost	0	0	0	0
Salaries & Ins. Benefits	115,175.26	123,188.63	60,613.77	82,340.33
Staff Development	40,000.00	0	0	0
Staff Expense	11,700.00	7,400.00	3,000.00	14,200.00
President Expense	12,000.00	0	0	0
President-Elect Expense	6,000.00	0	0	0
Officer Honorariums	19,000.00	0	0	0
Council Expense	63,000.00	0	0	0
AMA Del/Alt Expense	0	0	0	0
Student Business Section	0	0	0	9,100.00
Annual Meeting	0	124,192.00	0	0
Bad Debt Expense	0	0	0	0
Building Expense	3,277.64	5,234.44	2,152.48	3,179.80
Car Lease	14,000.00	0	2,600.00	7,200.00
Contributions	0	0	0	0
Councilor Dist. Conference	10,000.00	0	0	0
Data Processing	0	9,200.00	0	4,600.00
Depreciation Expense	2,873.00	2,691.00	1,053.00	1,417.00
Equipment Lease & Supply	1,742.40	5,148.00	1,742.40	2,574.00
Equipment Maint. Agreement	220.00	650.00	220.00	325.00
Emergency Fund	1,478.40	1,465.20	1,465.20	1,465.20
Insurance and Bonding	20,596.80	1,612.80	1,612.80	1,612.80
Interest Expense	876.11	1,276.42	645.78	855.99
Legal Expense	75,000.00	0	0	0
Library	560.00	255.00	555.00	555.00
Meeting Expense	12,000.00	0	0	5,000.00
Misc. Supplies	440.00	1,300.00	440.00	650.00
OSMAgram	0	0	0	0
Pension Expense	5,580.00	6,180.00	3,060.00	4,140.00
Postage	2,200.00	6,500.00	1,950.00	3,250.00
Printing & Office Supply	1,260.00	5,200.00	1,260.00	1,600.00
Prof. Relations Activity	481.27	1,469.14	2,330.35	481.27
Public Relations Expense	0	0	0	0
Taxes: Payroll	3,956.28	9,077.88	3,457.31	5,318.17
Taxes: State and Local	0	0	0	0
Telephone and Telegraph	8,200.00	5,600.00	3,000.00	3,200.00
Total 1982 Budget	\$443,399.46	\$340,227.17	\$106,812.89	\$165,946.65

All Departments

(continued on page 146)

05 Fiscal Membership	06 Government Relations	07 Commun- ications	08 Organization Services	09 State & Fed. Legislation	10 Rental Area	1982 Budget Totals
77,900.00	0	2,000.00	4,500.00	1,500.00	0	91,450.00
3,766.34	1,657.19	2,686.66	2,887.54	4,142.99	2,862.43	25,109.00
0	0	186,000.00	0	0	0	186,000.00
227,766.96	158,007.23	151,603.98	121,717.46	191,356.61	0	1,231,770.23
0	0	0	0	0	0	40,000.00
11,000.00	18,000.00	9,000.00	9,000.00	48,000.00	0	131,300.00
0	0	0	0	0	0	12,000.00
0	0	0	0	0	0	6,000.00
0	0	0	0	0	0	19,000.00
0	0	0	0	0	0	63,000.00
0	0	0	71,075.00	0	0	71,075.00
0	0	0	0	0	0	9,100.00
0	0	0	0	0	0	124,192.00
0	0	500.00	0	0	0	500.00
7,338.00	3,228.72	5,234.44	5,625.80	8,071.80	5,576.88	48,920.00
2,700.00	8,100.00	2,700.00	2,800.00	2,720.00	0	42,820.00
0	0	0	0	0	0	0
0	0	0	0	0	0	10,000.00
23,000.00	0	4,600.00	2,300.00	2,300.00	0	46,000.00
37,057.00	1,365.00	3,393.00	2,535.00	4,134.00	1,482.00	58,000.00
9,464.40	2,574.00	6,019.20	4,316.40	6,019.20	0	39,600.00
1,195.00	325.00	760.00	545.00	760.00	0	5,000.00
1,465.20	1,465.20	1,465.20	1,465.20	1,465.20	0	13,200.00
1,646.40	1,612.80	1,646.40	1,612.80	1,646.40	0	33,600.00
1,706.89	866.00	1,276.42	1,356.50	1,857.01	1,141.16	11,858.28
0	840.00	0	0	0	0	75,840.00
555.00	555.00	555.00	555.00	555.00	0	4,700.00
0	2,500.00	1,500.00	0	0	0	21,000.00
2,390.00	650.00	1,520.00	1,090.00	1,520.00	0	10,000.00
0	0	40,000.00	0	0	0	40,000.00
10,740.00	6,300.00	7,500.00	6,180.00	10,320.00	0	60,000.00
11,950.00	3,250.00	7,600.00	5,450.00	7,600.00	0	49,750.00
8,560.00	2,100.00	6,080.00	3,360.00	10,580.00	0	40,000.00
481.27	2,983.95	481.27	481.27	975.21	0	10,165.00
0	0	60,000.00	0	0	0	60,000.00
15,979.18	8,485.47	10,227.80	6,430.89	12,859.51	0	75,792.49
0	0	0	0	0	0	0
6,800.00	4,400.00	6,200.00	4,400.00	8,000.00	0	49,800.00
\$484,461.64	\$239,765.56	\$521,949.37	\$260,483.86	\$329,632.93	\$ 11,062.47	\$2,903,742.00

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A RESURVEY OF OHIO FAMILY PHYSICIANS

A Projection of Future Needs to the Year 2000

Lauren M. Brown, M.D.
Tennyson Williams, M.D.
Department of Family Medicine
The Ohio State University

Family physicians practicing in Ohio were surveyed. Compared to the ideal ratios used in the Lawton Studies of Florida, Ohio has approximately 50% the number of family physicians needed. In order to fill this need, as well as the needs for population growth and physician attrition, approximately 77 new first-year family practice residency positions are needed. When correlated with data of student selection of family practice residencies and of family practice residencies, however, it is evident that there must be a moratorium on establishing new positions until there is further increase in student selection of family practice residencies.

In 1974, THE OHIO LEGISLATURE enacted House Bill 474.¹ This legislation mandated the establishment of family medicine departments in all Ohio medical schools that receive any state subsidy. At that time, four approved medical schools existed within the state. Since then, two medical schools granting the M.D. degree and one medical school granting the D.O. degree have been established. As the family medicine departments became realities, it became imperative that someone survey the current family physician population of the state, the projected retirement of these physicians, the current population of Ohio and the projected population growth in order to assess the current and future needs for family physicians. This study is a five-year update of a 1975 study by the same authors.² We hope to continue to update on a five-year basis.

Method

To determine who was practicing family/general medicine in the State of Ohio at the time of the survey, each of the 88 counties was assessed separately. A family physician known personally to one of the investigators was identified in each county. A master list of physicians was prepared for each separate county using the American Medical Association and the American Osteopathic Association directories. These lists were validated and updated by these local physicians. In all cases, the final list was the responsibility of the local contacts.

After identifying these physicians, we determined each of their ages from directories, association records, and in a few cases, personal contacts.

A separate table was made for each county, and each identified practicing physician was projected as continuing practice until he reached the age of 65 years. While they may be an er-

roneous assumption, the increasing cost of malpractice insurance premiums precludes most physicians from continuing to practice to the ages customary in the past. A few early deaths will be compensated for by physicians older than 65 years who continue to practice. Five-year time spans were used: 1980, 1985, 1990, 1995, and 2000.

Each physician is counted as one unit until the five-year period when he/she reaches 65 years of age and is subsequently deleted from our figures. Any physician now practicing beyond the age of 65 years was counted as one-half a unit until 1985 when they were deleted. A summary of these figures by counties is shown in the table.

The current population figures and the projected population growth for the five-year spans from 1980 until the year 2000 were compiled by Ohio Department of Economic and Community Development and are summarized as follows:³

1975 - 10,735,000
1980 - 10,797,418
1985 - 10,904,437
1990 - 11,078,982
2000 - 11,428,072

These figures project a population increase of 693,072 persons by the year 2000.

The literature was reviewed to determine a valid ideal family physician/patient ratio.⁴⁻¹⁰ Knowles¹¹ and Schonfeld¹² have thoroughly addressed the variables which make such ratios difficult to assess.

The consensus of these reports is best expressed by Lawton,¹³⁻¹⁴ and we have chosen to use his ratio of 45 family physicians/100,000 population.

Results

Presently, there are 2,405.5 family physicians practicing in Ohio. The current deficit for an ideal relationship (one family physician to 2,222 people) is 2,453 family physicians (see figure). It should also be noted that Ohio has 203 less family phy-

Dr. Brown, Akron, Director, Barberton Area Family Practice Residency Program; Active Staff, Barberton Citizen's Hospital; Courtesy Staff, The Ohio State University Hospitals; and Clinical Associate Professor, Department of Family Medicine, The Ohio State University College of Medicine.

Dr. Williams, Dublin, Attending Staff, The Ohio State University Hospitals; Courtesy Staff, Children's Hospital, Columbus; Professor and Chairman, Department of Family Medicine, The Ohio State University College of Medicine.

Submitted December 17, 1981

sicians in 1980 than they had in 1975 (see figure). This is worsened when we consider a population increase of 62,418 in the five years from 1975-1980. With the projected population increase to 11,428,072 by the year 2000 (an increase of 630,654 people) an additional 284 family physicians are needed (see figure).

In the year 2000, Ohio will need 5,143 family physicians. It is projected 1,746.5 of the now-practicing family physicians will cease to practice within these 20 years. These 1,746.5 family physicians added to the current deficit of 2,453, plus the 284 needed for population increase, project a need for 4,483.5 new family physicians within the next two decades.

Discussion

Currently, there are 147 first-year family medicine residency positions available within the State of Ohio.¹⁵ If all of these positions were filled by residents who stayed within the state to practice, there would be 2,940 new physicians by the year 2000. This projects a deficit of 1,543.5 within this period of time.

Approximately 15% of the current medical school graduates are now opting for family medicine. Willard¹⁶ has stated that 25% of the graduating students are needed in family practice. Our statistics validate this need to prevent the projected deficits.

It is apparent that Ohio is still in need of family physicians and that additional residency positions will be needed when sufficient new students elect the specialty of family medicine.

Replacement of attrition and fulfilling the needs of projected population growth will require approximately 101 new family physicians annually in Ohio. Ohio's Family Practice Residency Programs graduated 101 residents in 1981. A review of actual county physician lists suggest that the influx of family physicians trained outside Ohio is about equal to the out migration of Ohio-trained family physicians. Ohio programs retain 60% 70% of graduates in Ohio. The excess of positions needed, thus, is primarily to correct the current deficit. When this deficit is corrected, these positions (approximately 123) will no longer be needed. It would be much easier to decrease positions in existing programs than to close entire programs. Therefore, it would be reasonable to recommend that new positions should be added to existing programs in preference to creating new family practice residency training programs.

At present, some 15% of first-year family medicine residency positions in Ohio are vacant. It is critical that these positions become filled.

Data collected since 1974 by The Ohio State University Department of Family Medicine reveal that the fill rate of Ohio Family Practice Residency Programs has decreased annually since 1978 (Graph 1). When compared to the number of students selecting family practice residencies, there appears to be a one year lag in residency fill rate when there is a change in medical student graduate's selection of family practice residencies.

Since 1974, there have been 12 new family practice residency positions added annually. Student interest leveled off from 1977 to 1980¹⁷ (Graph 2). Combining the data of Graph 1 and Graph 2 provide evidence to suggest that, despite the need demonstrated by the study of practicing family physicians, there should be a moratorium on establishing additional residency positions until the student pool increases; otherwise, a continued decline in fill rates can be predicted. Residency directors must be aware that in 1983 both Ohio State and the Medical College of Ohio will have smaller graduating classes due to the transition from the three to the four-year medical school curriculum.

Continuing survey of students, residents, and practicing physicians should provide the data to indicate when it is pru-

dent to increase residency positions and the ultimate number that may be needed.

Conclusions

1. There are 203 less family physicians in 1980 than in 1975.
2. Ohio has a current deficit of family physicians.
3. The deficit of family physicians will increase dramatically by the year 2000 as presently practicing family physicians cease to practice unless replacement occurs.
4. There are presently insufficient first-year family medicine residency positions available in the State of Ohio to correct the projected deficit.
5. There are insufficient student applicants to fill current positions.
6. A method of attracting more students to family medicine is needed.
7. Studies such as this are constantly needed for family medicine to have an orderly growth.
8. As physician deficit is increased, existing family practice residency slots will need to be deleted.

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1980 OHIO FAMILY PHYSICIAN MANPOWER STUDY

County	Actual		Estimated Family Physicians			
	FP 1975	FP 1980	1985	1990	1995	2000
Adams	4	4	4	4	4	2
Allen	29.5	31.5	26	19	8	7
Ashland	15.5	16	13	10	8	6
Ashtabula	19	20	15	12	9	5
Athens	13	14	12	10	8	8
Auglaize	16	11	9	7	6	5
Belmont	29.5	28	23	16	11	8
Brown	6.5	7.5	6	4	2	2
Butler	36	36	29	22	11	8
Carroll	3	9	6	4	4	3
Champaign	12	14	9	8	6	5
Clark	26.5	21.5	15	11	9	4
Clermont	16.5	19.5	17	13	9	3
Clinton	10.5	10	7	4	4	4
Columbiana	18.5	17.5	10	6	5	5
Coshocton	10.5	8.5	6	4	2	2
Crawford	18.5	17.5	13	10	9	6
Cuyahoga	195.5	186.5	117	89	55	38
Darke	20.5	15.5	15	10	9	7
Defiance	10.5	9	6	3	2	2
Delaware	12.5	11	7	6	6	4
Erie	29	12	8	7	4	3
Fairfield	26	26	19	17	11	8
Fayette	9.5	8	5	3	0	0
Franklin	255.5	219	158	117	90	71
Fulton	16.5	16	14	10	6	4
Gallia	7	4.5	4	1	1	1
Geauga	10.5	11.5	11	9	3	1
Greene	29	32.5	27	18	13	10
Guernsey	11	9.5	6	3	1	0
Hamilton	183.5	177	136	85	50	33
Hancock	12.5	8	7	7	4	2
Hardin	7	10	6	6	5	5
Harrison	7	8	7	5	4	2
Henry	5	7.5	7	6	2	0
Highland	10	8.5	7	4	3	1
Hocking	8.5	6.5	5	5	4	4
Holmes	8	8.5	7	7	5	3
Huron	10.5	18.5	17	11	8	4
Jackson	10.5	7.5	4	4	3	0
Jefferson	18	15.5	14	9	6	4
Knox	11	11	9	7	7	6
Lake	31.5	22.5	18	13	6	4
Lawrence	10.5	12	9	8	5	4
Licking	34	31	27	21	18	15
Logan	14	14	12	10	8	7
Lorain	58	64.5	48	33	18	12
Lucas	211.5	176.5	136	109	74	44
Madison	11.5	14	7	7	6	2
Mahoning	62	46	34	23	11	7
Marion	11	7	1	1	1	1

1980 Ohio Family Physician Manpower Study (continued)

Medina	20.5	29.5	25	20	13	12
Meigs	5	10	7	6	6	5
Mercer	11	10	7	6	6	2
Miami	30	27	22	18	13	7
Monroe	2	3.5	3	3	3	3
Montgomery	226.5	183.5	158	125	89	61
Morgan	2.5	2.5	2	1	1	1
Morrow	4	7.5	5	4	4	3
Muskingum	16.5	14.5	9	4	1	1
Noble	3.5	3.5	3	3	1	0
Ottawa	13	16	13	11	8	6
Paulding	6	5	3	3	3	2
Perry	4.5	5.5	3	3	2	2
Pickaway	12.5	13.5	9	8	6	4
Pike	7.5	8.5	7	6	6	2
Portage	37.5	24	21	17	10	4
Preble	11	9	8	7	5	4
Putnam	6	9	9	6	6	5
Richland	24.5	20.5	15	13	10	5
Ross	13	10.5	7	3	1	0
Sandusky	17	9.5	5	4	3	1
Scioto	27.5	22	11	8	7	3
Seneca	17	15	11	10	4	2
Shelby	7	8	8	7	7	6
Stark	89.5	82.5	64	51	36	21
Summit	120.5	111	92	69	53	42
Trumbull	71	52	41	32	15	8
Tuscarawas	27	20.5	18	13	9	8
Union	10.5	11.5	9	5	2	2
Van Wert	10	8.5	7	4	4	3
Vinton	2	1	1	1	1	1
Warren	18.5	33	28	23	20	11
Washington	10	16	15	8	6	6
Wayne	29	41	31	24	14	13
Williams	12.5	12	9	7	6	5
Wood	23	22.5	15	9	8	5
Wyandot	6	6	6	4	2	1
Totals	2,608.5	2,405.5	1,842	1,384	955	659
Needed	4,831	4,859	4,908	4,986	5,065	5,143
Deficit	2,222	2,454				

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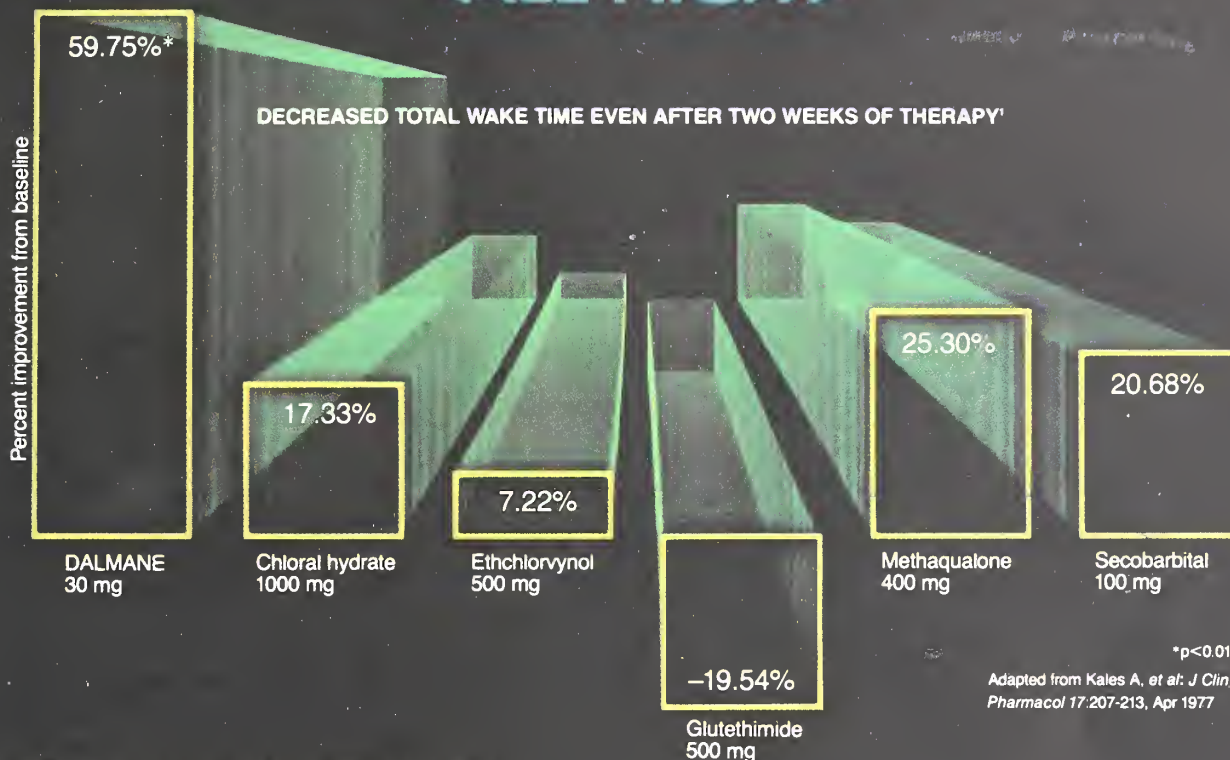
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(related charts are on page 123)

ACKNOWLEDGEMENTS

The authors are grateful to Eileen E. Merrick for following up contacts, tabulating results, and typing the manuscript; to Ms. Debbie Jones, the Ohio State Medical Board, and to Ms. Beth Fraley, the Ohio State Medical Association, for their valuable assistance in gathering statistical data.

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- which can require careful monitoring in cardiovascular patients¹⁰
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- which are *not* reliable sleep-inducing agents¹¹
- which may produce stimulation instead¹¹
- which have anticholinergic effects¹¹

Major tranquilizers

- whose side effects may be troublesome for nonpsychotic patients¹²
- where tolerance for sedation appears rapidly¹²

Dalmane does not cause significant worsening of sleep beyond baseline levels upon discontinuation.⁴

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect.

Adults: 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

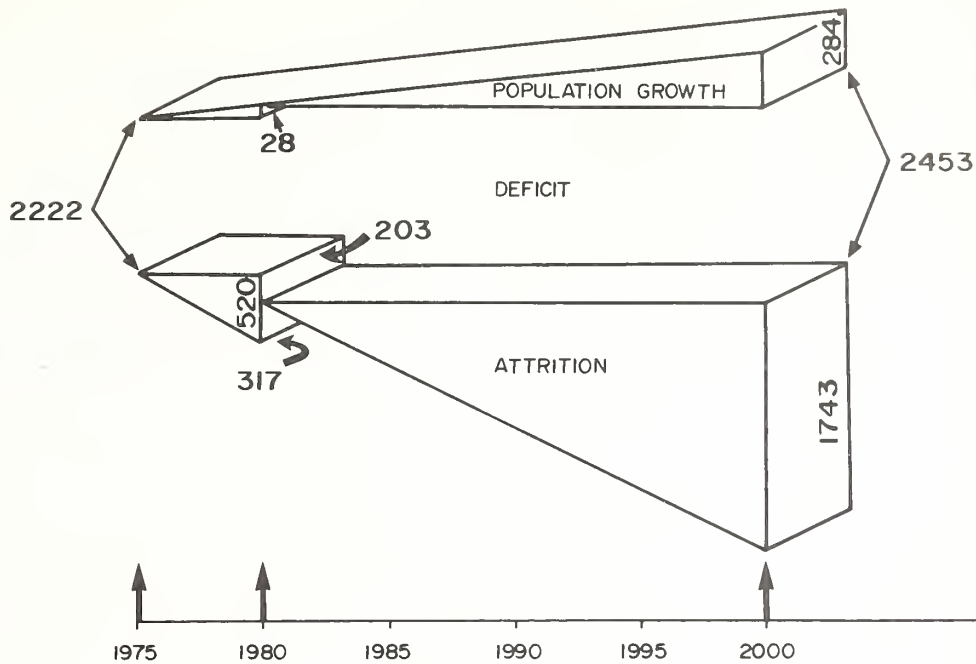
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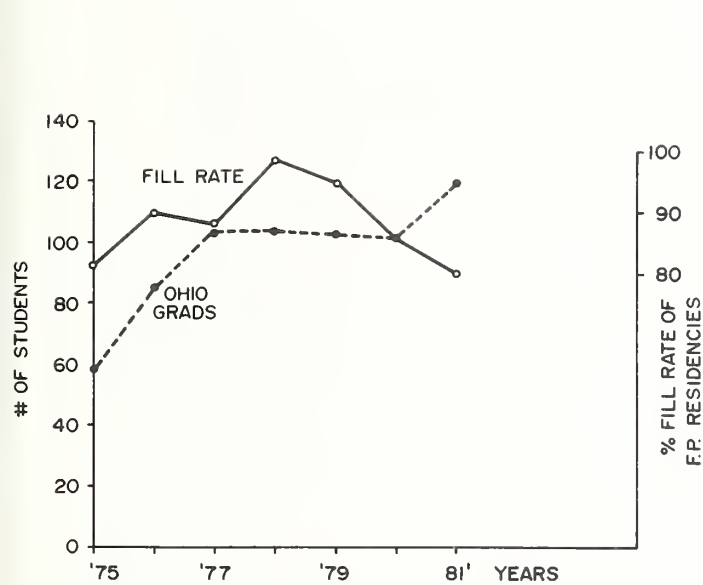
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Resurvey of Ohio Family Physicians

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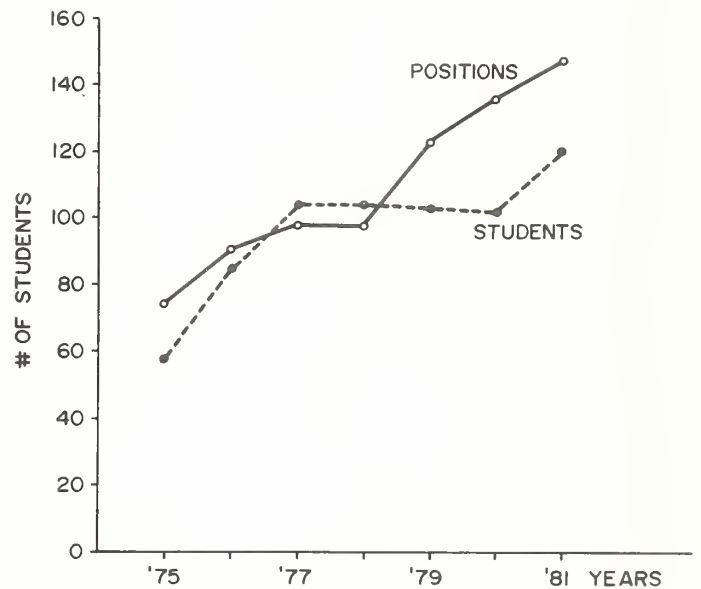


Family physician needs to correct deficit, replace attrition, and fulfill need of population growth in Ohio to the year 2000.



Graph 1

Relationship between the fill rate (%) of Ohio Family practice residencies and the number of Ohio medical school graduates selecting family practice residencies, 1975 to 1981.



Graph 2

Relationship between number of first-year family practice residency positions in Ohio and number of Ohio medical students available for these positions, 1975 to 1981.



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PROCEEDINGS OF THE COUNCIL

December 12, 1981

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, December 12, 1981, at the OSMA Headquarters, 600 South High Street, Columbus, Ohio.

Those present were: Stewart B. Dunsker, M.D., Cincinnati; C. Douglass Ford, M.D., Toledo; Robert G. Thomas, M.D., Elyria; David A. Barr, M.D., Lima; John E. Albers, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; Alford C. Diller, M.D., Van Wert; Benjamin H. Reed, M.D., Delta; Edward G. Kilroy, M.D., Cleveland; Joseph P. Yut, M.D., Canton; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; A. Burton Payne, M.D., Ironton; David James Hickson, M.D., Mt. Gilead; S. Baird Pfahl, Jr., M.D., Sandusky; Joseph L. Kloss, M.D., Akron; Oscar W. Clarke, M.D., Gallipolis; W. J. Lewis, M.D., Dayton; John H. Ackerman, M.D., Director ODH, Columbus; James E. Pohlman, Esq., Columbus; Thomas Helmrath, M.D., Columbus; Evelyn L. Cover, D.O., OSMB, Columbus; and Shirley C. Davies, President, OSMA Auxiliary.

Those present from the OSMA Staff were: Hart F. Page; Herbert E. Gillen; Jerry J. Campbell; Katherine E. Wisse; D. Brent Mulgrew; Gail E. Dodson; Rebecca J. Doll; David C. Torrens; Carol W. Mullinax; David W.

Pennington; Eric Burkland; Michael L. Bateson; Louis N. Saslaw; William E. Fry; and Catherine M. Costello.

Announcements by President Dunsker

The Council was called to order by Dr. Dunsker who introduced Thomas Helmrath, M.D., Vice Chancellor of Health Affairs, Ohio Board of Regents.

Dr. Helmrath indicated that he expects Federal cutbacks in medical education to be more marked next year. He added that Family Practice and Family Care Department funds from the State of Ohio have been retained.

Mrs. Shirley Davies, president of the Ohio Auxiliary to the OSMA, was introduced and addressed the Council.

Dr. Evelyn Cover, President of the Ohio State Medical Board, addressed the Council on the following subjects of current concern:

1. Physicians prescribing practices as governed by Federal law.
2. Ohio Laws governing physicians' assistants.
3. Licensure of graduates of foreign medical schools.
4. The Medical Board budget and escalation of license fees contained in the budget bill. (Renewal fees are raised from \$50 every 3 years to \$100 every 2 years.)
5. HB 317 reforms on investigation and enforcement procedures of the Board.
6. Prescribing amphetamines for weight reduction purposes.

Dr. Clark and Dr. Yut discussed several of these subjects from their viewpoints as members of the Medical Board.

Dr. Dunsker reported on the Councilor District meetings during the fall and urged continued efforts by Councilors to join with other districts for combined district conferences.

He asked for suggestions from each Councilor for names of members to serve on reference committees of the House.

He announced the appointment of Dr. A. Robert Davies to the Advisory Committee on Health Affairs for the Ohio Board of Regents.

He discussed a meeting on Medicaid held at the Ohio State University on

November 23 and 24.

The April meeting of the Council was changed from April 24 to Noon on April 29.

Administration

The following minutes were approved: the meeting of September 12, 1981, and the meeting of October 31, 1981. The minutes of the September 30, 1981 conference call **were ratified and approved.**

Mr. Page introduced Mr. Joseph Moore who is in charge of building maintenance for the OSMA.

Mr. Page announced the receipt of a letter from Charles J. Everett, M.D., President, Erie County Medical Society, nominating Dr. Pfahl for office of President-Elect.

Financial and Membership Department

Committee on Auditing and Appropriations — Dr. Pfahl presented the minutes of the December 11, 1981 meeting of the Committee on Auditing and Appropriations.

The Council **approved** expenditures of \$500 for capitalization expense for a proposed for-profit corporation.

The Articles of Incorporation of the new corporation **were approved.**

The Council expressed the "sense" that the new corporation proceed with marketing plans for the tape-to-tape data entry system.

The Council **approved** the Committee's recommendation that a Data General C-350 with 768 Kb of memory be purchased from Cards. Further, that a five-year lease/purchase agreement be entered into with Cards subject to renegotiation within six months. (Dr. Diller abstaining. Dr. Yut dissenting.)

Dr. Pfahl presented the proposed 1982 budget of \$2,903,742 and it was **approved** by official action.

The report of the Committee was **approved.**

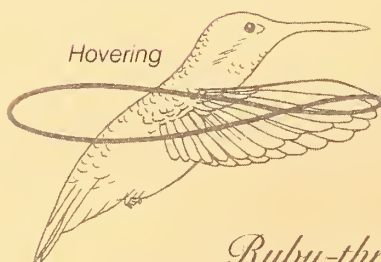
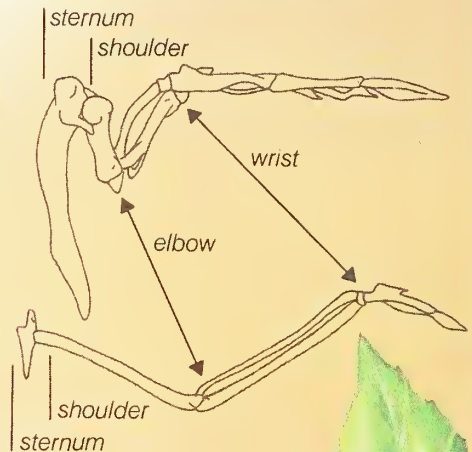
Treasurer's Report — The Treasurer's report was presented by Dr. Barr and was accepted.

Problems of federation membership were referred for study to the Committee on Membership.

Problems of federation billing presented by the Summit County

One of nature's most distinctive designs...

Compared with a typical bird wing (lower drawing), the "hand" portion of the hummingbird wing (upper drawing) is greatly enlarged, while the elbow and wrist are small and rigid. Maneuverability occurs only at the shoulder. This structure actually permits the hummingbird to hover and fly backwards like a helicopter.



Ruby-throated Hummingbird
(*Archilochus colubris*)



HUMMINGBIRD METABOLISM.

The hummingbird is the smallest bird on earth—some species weigh no more than a dime. It has the highest rate of metabolism (at rest, about 50 times faster than man's) and thus must consume enormous amounts of nectar to avoid starvation. Not adapted for nightfeeding, it must stretch its food stores from dusk to dawn. To accomplish this, nature has equipped the hummingbird with a unique energy-saving design: the ability to *hibernate* overnight.

During the night, the hummingbird's metabolic rate is only one-fifteenth as rapid as in the daytime, and its body temperature drops to that of the surrounding air. The bird becomes torpid, scarcely able to move. When it does stir, it moves as though congealed. By daybreak, the hummingbird's body spontaneously resumes its normal temperature and high metabolic rate, ready once again to dart off in search of food.

Few birds have such a distinct pattern of metabolic action.

In medicine, few drugs can match the distinctive pattern of therapeutic action that you can expect with Librium. While promptly and effectively relieving the symptoms of anxiety, Librium rarely affects mental acuity at proper doses. It may be used safely in anxious geriatric and cardiovascular disease patients. Caution patients about driving, operating hazardous machinery or drinking alcohol while on Librium therapy.



For the relief of anxiety

5 mg, 10 mg, 25 mg capsules
Librium®
 chlordiazepoxide HCl/Roche
 one of man's

Librium® C

(chlordiazepoxide HCl/Roche)

5 mg, 10 mg, 25 mg capsules

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders; short-term relief of anxiety symptoms, acute alcohol withdrawal symptoms, preoperative apprehension and anxiety. Usually not required for anxiety or tension associated with stress of everyday life. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Known hypersensitivity to drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) reported after abrupt cessation of extended use of excessive doses are similar to those seen with barbiturates. Milder symptoms reported infrequently when continuous therapy is abruptly ended. Avoid abrupt discontinuation, gradually taper dosage.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Due to isolated reports of exacerbation, use with caution in patients with porphyria.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction, changes in EEG patterns (low-voltage fast activity) may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety disorders and symptoms, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. *Geriatric patients:* 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl/Roche) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50. Libritabs® (chlordiazepoxide/Roche) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

Medical Society were referred to the Committee on Auditing and Appropriations.

It was announced that the OSMA tape-to-tape data entry system is in the final stages of development.

Department of Education and Meeting Management

Committee on Education — Mrs. Dodson presented the minutes of the October 29, 1981 meeting of the Committee on Education.

They were accepted for information.

Department of Government Relations

Mr. Pennington introduced Mr. William E. Fry, new associate in the Department of Government Relations.

The department report was presented in writing for Council information.

Committee on Government Relations

— Mr. Pennington presented the November 18, 1981 minutes of the Committee on Government Relations.

The Council reaffirmed the OSMA commitment to preserve the right of patients in Governmental Medical Care programs to freedom of choice in the selection of a physician.

The committee report was filed.

Dr. Reamy presented a progress report on the meeting of the Ad Hoc Committee on House of Delegates voting procedure, which met December 11, 1981.

Ad Hoc Committee on Incentive/

Disincentive — Dr. Abromowitz presented a report of the December 11, 1981 meeting of the Ad Hoc Committee on Incentive/Disincentive.

The Council accepted a memorandum dated December 12, 1981 regarding the "Ohio Medical Indemnity Mutual Participation Agreement Program for Physicians and Other Providers."

Ohio Voluntary Effort — Dr. Abromowitz, as its chairman, presented a report on the Ohio Voluntary Effort.

The report was accepted.

Department of Organization Services

Ad Hoc Committee on Medical Services Review — Dr. Diller presented the November 20, 1981 minutes of the Ad Hoc Committee on Medical Services Review.

The Council amended and adopted a committee recommendation that OSMA does have an appropriate role in fee review and further, that OSMA became involved in fee review to properly represent physician members and patients. (Dr. Yut dissenting.)

The OSMA staff was instructed to propose a review structure to the Ad Hoc Committee on Medical Services Review.

Proposed changes in OSMA Specialty Society contracts at renewal were submitted by Mr. Campbell for consideration of the Council and were approved.

American Medical Association — Drs. Lewis and Clarke presented a report on the AMA Interim Meeting in Las Vegas December 6-9, 1981. A comprehensive review will be published in the February 1982 issue of the *Ohio State Medical Journal*.

Department of Health Education

Committee on Mental Health — Mr. Gillen presented the minutes of the October 28, 1981 meeting of the Committee on Mental Health.

The Council approved cooperation with the Ohio Psychiatric Association, and the Ohio Academy of Family Physicians to develop a model for care of chronic mental patients.

With regard to legislation relative to insurance coverage for mental and emotional disorders and alcoholism, such items were referred by the Council to the Committee on Legislation.

The minutes were filed.

Department of Federal & State Legislation

Mr. Mulgrew presented the Federal Legislation report and introduced Ms. Cathy Costello, a lawyer and new member of the legislative department staff.

Mr. Burkland presented the State Legislation report.



Roche Products Inc.
Manati, Puerto Rico 00701

Premarital Serology testing was repealed as part of the budget as mandated by the House of Delegates.

He announced that under amendment obtained by OSMA, log books no longer need be submitted to the Ohio State Medical Board, but should be maintained and retained for spot checks by the Board.

Mr. Bateson reviewed the passage of the OSMA sponsored brain death bill. (Which was signed by the governor December 14, 1981.)

The Council voted to thank Rick Ayish, who has become affiliated with Ohio Medical Indemnity Mutual, for his fine service to OSMA and to wish him well in his new position.

Committee on Organization Structure

— The minutes of the Committee on Organization Structure meeting of November 18, 1981 were presented by Mr. Mulgrew for information.

Department of Communications

The report of the Department of Communications was presented in writing, covering the *OSMA Journal*, *Synergy* and the Media operations.

The report was filed.

The Council voted to present a commendation at the next House of Delegates to Dr. Richard L. Meiling for his work with the *Ohio State Medical Journal*.

It was voted to invite Dr. Sylvan Weinberg to meet with the Council to discuss suggestions with regard to the *Ohio State Medical Journal*.

Department of Field Service

Task Force on Marketing and Competition — Mr. Holcomb presented the minutes of the November 5, 1981 meeting of the Task Force on Marketing and Competition.

With regard to a suggestion for a referral audit and marketing audit, the Council **voted to endorse** the concept and to refer the minutes back to the committee for further study and report.

With regard to the Physician Practice Opportunity Program market survey, the Council referred it back to the Task Force for a review and evaluation of the program before re-submission to the Council.

Medical Student Liaison Committee

— Mr. Saslaw presented the minutes of the October 11, 1981 meeting of the Medical Student Liaison Committee and the Council voted, as indicated below, with regard to each item:

1. That the OSMA investigate sources of financial aid for medical education and serve as a clearinghouse for this type of information — **approved**.
2. That OSMA act as a clearinghouse and coordinator of extended (summer) preceptorships for first and second-year students and clerkships for third and fourth-year students — **referred back to the committee for more specifics, and cost determination**.
3. That OSMA sponsor a softball tournament with teams from the medical schools, OSMA and PICO — **failed**.
4. That a meeting be established with two faculty or staff representatives from each school and appropriate county societies for purpose of establishing continuity in each school regarding Medical Student Section activities — **approved**.
5. That OSMA investigate the feasibility of providing insurance packages for students in health, life, "renter's," etc. — **ongoing**.
6. That OSMA investigate the possibility of students working at "health" booths (taking blood pressures) at state and county fairs — **approved**.
7. That a student questionnaire similar to the key physician brochure be developed to establish a key student program — **adopted**.
8. That at least one program on the medical school campuses be developed which would include young practicing physicians. The format will be experimented with and will be tailored to the particular school — **adopted**.

The report was filed.

Councilor Reports

The Councilors reported on the activities in their respective districts.

Constitution and Bylaws Amendments

Amendments to the Bylaws of Lake, Portage, Geauga, Trumbull and Montgomery County Medical Societies were presented by Mr. Mulgrew and **were approved**.

Legal Counsel Report

Mr. Pohlman reviewed several legal cases which are pending in the courts.

Ohio Director of Health

Dr. John Ackerman, Ohio Director of Health, addressed the Council with regard to current public health problems.

There being no further business, the meeting was adjourned.

ATTEST: Hart F. Page, CAE
Executive Director

Insomnia may be signal for other problems

A two-day workshop on "Diagnostic and Therapeutic Issues in Insomnia," chaired by Dr. William Dement, President of the Association of Sleep Disorders Centers, concluded that insomnia is a sign — much like a high fever — that can result from numerous medical and psychiatric conditions.

A report of the workshop in the Alcohol, Drug Abuse and Mental Health Administration's *News* said that diagnosis and treatment of such conditions also were discussed, with a number of speakers examining the widespread and often precarious use of hypnotic medications or "sleeping pills."

Participants concurred that physicians should know the general "parameters of safety" for each hypnotic they prescribe, whether or not it could be used in an overdose, and what its addicting potential might be. Other information deemed essential concerned potential interactions with other drugs and the "duration of action" of each hypnotic.

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The offer is made only by the Prospectus.*

NEW ISSUE
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PRORECO Reinsurance Corporation, Ltd. was recently incorporated under the laws of the Cayman Islands, British West Indies, and has not yet commenced its proposed reinsurance business. Initially, PRORECO will emphasize the reinsurance of medical professional liability insurance risks.

Initially, these shares are available only to persons or entities that reside in certain states and who owned of record on June 30, 1981, one or more shares of the Class A Common Stock of Physicians Insurance Company of Ohio (PICO). Thereafter, the shares will be available to members of The Ohio State Medical Association.

Copies of the Prospectus may be obtained only from the undersigned Selling Agent.

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155 East Broad Street
Columbus, Ohio 43215

Obituaries



ROCCO ANTENUCCI, M.D., Mogadore: Ohio State University College of Medicine, 1960; age 49; died December 3, 1981; member OSMA and AMA.

CARL H. BAIR, M.D., Ventura, California; Ohio State University College of Medicine, 1914; age 89; died November 30, 1981; member OSMA and AMA.

CHARLES DEISHLEY, M.D., Columbus; Ohio State University College of Medicine, 1940; age 68; died December 8, 1981; member OSMA and AMA.

DE LOISE DOWNEY, M.D., Nokomis, Florida; Ohio State University College of Medicine, 1921; age 88; died November 28, 1981; member OSMA and AMA.

GUSTAV ECKSTEIN, M.D., Cincinnati; University of Cincinnati College of Medicine, 1924; age 91; died September 23, 1981; member OSMA and AMA.

DANIEL LESZKIEWICZ, M.D., Medina; Case Western Reserve University School of Medicine, 1963; age 57; died November 26, 1981.

EDWARD L. MILLER, M.D., Largo, Florida; Ohio State University College of Medicine, 1926; age 79; died October 14, 1981; member OSMA and AMA.

MICHAEL RABE, M.D., New Bremen; University of Leipsic, Germany, 1921; age 92; died November 10, 1981; member OSMA and AMA.

CHARLES RAMMELKAMP, M.D., Cleveland; University of Chicago School of Medicine, Chicago, Illinois, 1937; age 70; died December 5, 1981.

RAYMOND E. WEIGEL, M.D., Cleveland; University of Cincinnati College of Medicine, 1944; age 63; died October 28, 1981; member OSMA and AMA.

Correction

Ralph D. Yates, M.D. was erroneously listed as deceased in the December Journal. The Journal regrets the error and any confusion which may have been caused.

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CONTINUING EDUCATION PROGRAMS

March

SELECTED TOPICS IN THE CARE OF THE ELDERLY — AN UPDATE:

March 18; Holiday Inn, Troy; sponsor: Dettmer Hospital; 5 credit hours; fee: \$35, \$15 for nurses, students, physicians-in-training; contact: Gerard F. Wolf, M.D., 145 Sunset Drive, Piqua 45356, phone: 513/773-8323.

CLINICAL PROBLEMS IN

UROLOGY: March 11-12; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; 12 credit hours; fee: \$170, \$85 for physicians-in-training; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

REFRESHER SEMINAR IN PEDIATRICS FOR THE PEDIATRICIAN AND FAMILY PHYSICIAN: March 17-18; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; 12 credit hours; fee: \$100, \$50 for physicians-in-training; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

PSEUDOEPILEPSY — THE CLINICAL ASPECTS OF PSEUDOSEIZURES: March 24-25; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; 12 credit hours; fee: \$120, \$60 for physicians-in-training; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

NUTRITIONAL SUPPORT: March 26; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; 6 credit hours; fee: \$80, \$40 for physicians-in-training; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

ADULT CONGENITAL HEART DISEASE: March 31; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; 6 credit hours; fee: \$60, \$30 for physicians-in-training; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

April

UPPER GASTROINTESTINAL ENDOSCOPY: EMERGENCY AND THERAPEUTIC ASPECTS: April 1-3; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; 15 credit hours; fee: \$325, \$160 for physicians-in-training; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

PEDIATRIC UPDATE — 1982: April 2-3; Quaker Square Hilton Inn, Akron; sponsor: Children's Hospital Medical Center, Akron; 12 credit hours; fee: \$90; contact: Max E. Griffin, M.D., 281 Locust Street, Akron 44308, phone: 216/ 379-8790.

SPORTS MEDICINE SYMPOSIUM: April 15-16; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; 13 credit hours; fee: \$120, \$60 for physicians-in-training; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

USING LASER IN GLAUCOMA: April 17; Vernon Manor Hotel, Cincinnati; 8 credit hours; sponsor: Bethesda Hospital, Cincinnati; fee: \$300, \$150 for students or physicians-in-training; contact: Thomas J. O'Connor, Bethesda Hospital, Medical Staff Education, 619 Oak Street, Cincinnati 45206, phone: 513/559-6337.

May

MEDICAL PROGRESS FOR THE FAMILY PHYSICIAN: May 5-6; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; 12 credit hours; fee: \$100, \$50 for physicians-in-training; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

OPEN for small-volume business

Blue Shield announces that now, small volume physician offices can make use of its Ohio Provider Entry Network (OPEN) system, the paperless claims submission program which Blue Shield initiated in 1978.

Since then, OPEN has been practical only for large volume practices and those with their own computer equipment. However, Blue Shield can now place a terminal in a mutually agreed-upon location for all interested physicians to share.

Those interested may contact Alpha Stone, Blue Shield, OPEN Department, 614-438-3824.



***You know
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in Step-1
antihypertensive
therapy...***

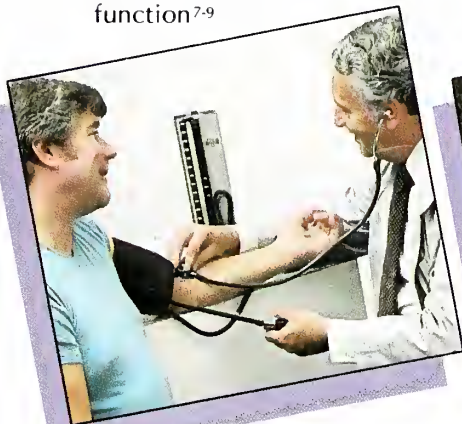
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Zaroxolyn[®] gives
(metolazone) Pennwalt

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Start with Zaroxolyn because of its unsurpassed effectiveness in Step-1 therapy.^{1,4}

Stay with Zaroxolyn because it maintains effectiveness in long-term therapy^{1,5,6}... and minimizes the need for Step-2 agents.

- ☐ Zaroxolyn's effectiveness is maintained even in the presence of reduced kidney function⁷⁻⁹



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Stay with Zaroxolyn because it maintains 24-hour blood pressure control with simple once-daily dosage, and only 4% discontinue therapy due to side effects!



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Stay with Zaroxolyn because clinically significant side effects are rare!

- ☐ Low incidence of changes in serum K⁺, glucose metabolism, or uric acid levels



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Add to Zaroxolyn easily if Step-2 agents become necessary.

- ☐ Permits lower doses of Step-2 agents to minimize side effects
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- ☐ Less expensive than most other diuretics
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Start with...stay with...and add to...

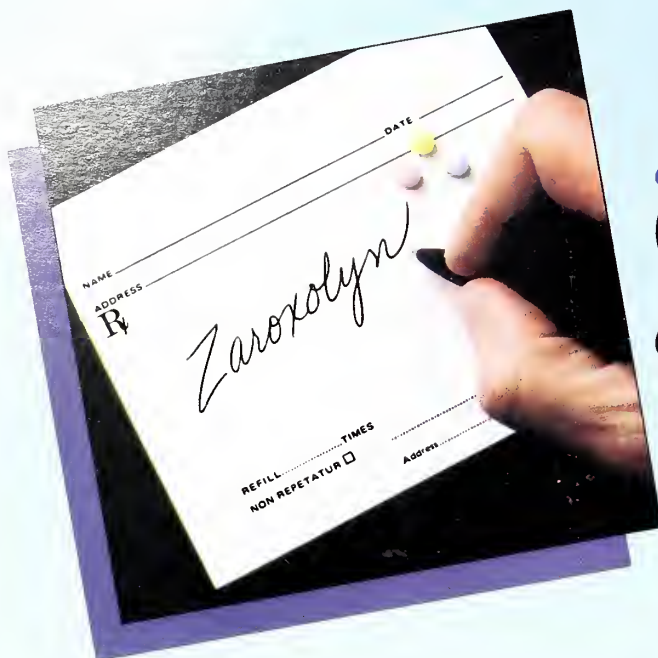
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Gives you what you want in
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Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaxoxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents, and also, edema associated with heart failure and renal disease. Routine use in pregnancy is inappropriate. **Contraindications:** Anuria, hepatic coma or precoma, allergy or hypersensitivity to Zaxoxolyn. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients, dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of childbearing age requires that potential benefits be weighed against possible hazards to the fetus. Zaxoxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance, namely hyponatremia, hypochloremic alkalosis and hypokalemia. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium

depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Insulin requirements may be affected in diabetics. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur. Zaxoxolyn 10 mg tablets contain FD&C Yellow No. 5 (tartrazine) which may cause allergic-type reactions (including bronchial asthma) in certain susceptible individuals. Although the overall incidence of FD&C Yellow No. 5 (tartrazine) sensitivity in the general population is low, it is frequently seen in patients who also have aspirin sensitivity. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment is usually necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

References: 1. Data on file, Medical Department, Pennwalt Pharmaceutical Division. 2. Sambhi MP, Eggena P, Barrett JD, et al: A crossover comparison of the effects of metolazone and hydrochlorothiazide therapy on blood pressure and renin angiotensin system in patients with essential hypertension, in Sambhi MP (ed): *Systemic Effects of Antihypertensive Agents*. New York, Stratton, 1976, pp 221-245. 3. Pilewski RM, Scheib ET, Misage JR, et al: Technique of controlled drug assay in hypertension: V. Comparison of hydrochlorothiazide with a new quinethazone diuretic, metolazone. *Clin Pharmacol Ther* 12:843-848, 1971. 4. Fotiu S, Mroczek WJ, Davidov M, et al: Antihypertensive efficacy of metolazone. *Clin Pharmacol Ther* 16:318-321, 1974. 5. Cangiano JL: Effects of prolonged administration of metolazone in the treatment of essential hypertension. *Current Therapeutic Research* 20:745-750, 1976. 6. Dornfeld L, Kane RE: Metolazone in essential hypertension: The long-term clinical efficacy of a new diuretic. *Current Therapeutic Research* 18:527-533, 1975. 7. Puscheck JB: Physiologic basis for the use of new and older diuretics in congestive heart failure. *Cardiovascular Medicine* 2:119-134, 1977. 8. Craswell PW, Ezzat F, Kopstein J, et al: Use of metolazone, a new diuretic, in patients with renal disease. *Nephron* 12:63-73, 1973. 9. Bennett WM, Porter GA: Efficacy and safety of metolazone in renal failure and the nephrotic syndrome. *J Clin Pharmacol* 13:357-364, 1973. 10. *Drug Topics Red Book 1981*, and manufacturers' suggested prices.

P DIVISION
PENWALT
ROCHESTER, NEW YORK 14623



NEW MEMBERS

ALLEN

Richard L. Damschroder, Lima

CLARK

Charles J. Zelnick, Yellow Spring

FRANKLIN

Paul Hrissikopoulos, Columbus

HAMILTON (Cincinnati unless noted)

Kishore Bhende
Carl L. Parrott, Jr.
Frederick J. Samaha

LUCAS (Toledo unless noted)

Paul D. Berlacher, Sylvania
Frank Chiu-Hui
Jason Ofori-Akyeah
John M. Pascoe
Roland T. Skeel
Charles B. Travis

MAHONING (Youngstown unless noted)

Ahsanul Karim Khan
Walwin D. Metzger
Narasimhulu Sarma

MONTGOMERY (Dayton unless noted)

Alan K. Jacobs
Gregg Pane
Bunyium Rojjanavaroe
Margaret Turk
David Zackowski, Trotwood

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Melvin D. Whitfield

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(PROPRANOLOL HCl)





THE CHOICE IS CLEAR

There was a time when you had little choice between such troublesome reserpine side effects as nasal stuffiness or depression, and the postural hypotension, sexual dysfunction, or development of tolerance to methyldopa. Today, it's a different story.

With **INDERAL** you have a logical choice. Patients rarely feel worse while they're getting better. And as far as tolerance is concerned—none has been reported with **INDERAL**. Its effectiveness is sustained, even in long-term therapy.


Proper patient selection is always important. **INDERAL** should be used only in the absence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma*.

INDERAL permits you to achieve smooth, effective control of blood pressure with few troublesome side effects*. Moreover, because side effects are usually not dose-related, higher doses can be prescribed with confidence.

INDERAL. The choice is clear when it comes to well-tolerated and effective control of hypertension.

INDERAL[®]
(PROPRANOLOL HCl)
**B.I.D. FOR
HYPERTENSION**
40 MG AND 80 MG TABLETS

*Please see following page
for Brief Summary of
Prescribing Information.



THE MOST WIDELY PRESCRIBED BETA BLOCKER IN THE WORLD

INDERAL® (PROPRANOLOL HCl) B.I.D. FOR HYPERTENSION

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)

INDERAL® BRAND OF propranolol hydrochloride A beta-adrenergic blocking agent

BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

CONTRAINDICATIONS

INDERAL is contraindicated in 1) bronchial asthma, 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE. Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta-blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. INDERAL acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by INDERAL's negative inotropic effect. The effects of INDERAL and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during INDERAL therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely: a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, INDERAL therapy should be immediately withdrawn, b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS DURING ANESTHESIA with agents that require catecholamine release for maintenance of adequate cardiac function, beta blockade will impair the desired inotropic effect. Therefore, INDERAL should be titrated carefully when administered for arrhythmias occurring during anesthesia.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, INDERAL should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since INDERAL is a competitive inhibitor of beta receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA. Because of its beta-adrenergic blocking activity, INDERAL may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY. The safe use of INDERAL in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit.

Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of INDERAL may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block; hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Miscellaneous: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (proctolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

ORAL

DOSAGE AND ADMINISTRATION

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 40 mg INDERAL twice daily, whether used alone or added to a diuretic. Dosage may be increased gradually until adequate blood pressure is achieved. The usual dosage is 160 to 480 mg per day. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

While twice-daily dosing is effective and can maintain a reduction in blood pressure throughout the day, some patients, especially when lower doses are used, may experience a modest rise in blood pressure toward the end of the 12 hour dosing interval. This can be evaluated by measuring blood pressure near the end of the dosing interval to determine whether satisfactory control is being maintained throughout the day. If control is not adequate, a larger dose, or 3 times daily therapy may achieve better control.

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

INTRAVENOUS

The intravenous administration of INDERAL has not been evaluated adequately in the management of hypertensive emergencies.

OVERDOSAGE OR EXAGGERATED RESPONSE

IN THE EVENT OF OVERDOSAGE OR EXAGGERATED RESPONSE, THE FOLLOWING MEASURES SHOULD BE EMPLOYED:

BRADYCARDIA—ADMINISTER ATROPINE (0.25 to 1.0 mg); IF THERE IS NO RESPONSE TO VAGAL BLOCKADE, ADMINISTER ISOPROTERENOL CAUTIOUSLY.

CARDIAC FAILURE—DIGITALIZATION AND DIURETICS.

HYPOTENSION—VASOPRESSORS, e.g., LEVATERENOL OR EPINEPHRINE (THERE IS EVIDENCE THAT EPINEPHRINE IS THE DRUG OF CHOICE).

BRONCHOSPASM—ADMINISTER ISOPROTERENOL AND AMINOPHYLLINE.

HOW SUPPLIED

INDERAL (propranolol hydrochloride)

TABLETS
No. 461—Each scored tablet contains 10 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

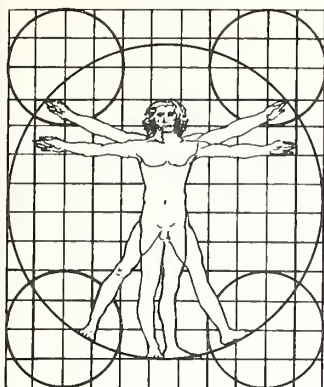
No. 462—Each scored tablet contains 20 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 464—Each scored tablet contains 40 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 468—Each scored tablet contains 80 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

INJECTABLE

No. 3265—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as: 1 ml ampuls in boxes of 10.



CLINICAL & SCIENTIFIC

CONSERVATIVE MANAGEMENT OF EARLY BREAST CANCER

Syed M. Rahman, M.D.
Jack E. Tetirick, M.D.
Ollie E. Southard, M.D.
George W. Callendine, Jr. Ph.D.

A conservative "breast-saving" approach to the treatment of early breast cancer is proposed as an alternative to the more commonly used radical mastectomy. Supportive background literature is cited. Our method, utilizing cobalt teletherapy with a focused boost by means of external beam therapy or iridium 192 ribbon implantation, is described in detail. Six patients have been so treated. Their early follow-up is encouraging.

If one wishes to propose a conservative procedure for the management of breast cancer, three conditions must be fulfilled. First, the long-term result of the conservative "breast-saving" treatment must be at least equal to radical or modified radical mastectomy. Second, conservative treatment must preserve a cosmetically acceptable breast which is almost normal in volume and firmness. Third, in case of failure of conservative treatment, local conditions must allow subsequent mastectomy to be carried out without complications.

There is evidence in the literature which suggests that radiation therapy, in the management of early breast cancer, can achieve local and regional control rates that are comparable to radical or modified radical mastectomy. Geoffrey Keynes,¹ a British surgeon, was one of the pioneers who introduced radiation therapy as primary treatment of breast cancer as early as 1929. He used radium needle implants in 75 patients where tumor apparently was confined to the breast and observed a five-year survival of 71%, compared to 69% for similarly staged patients treated by radical mastectomy.

George Pfahler,² a radiologist in Philadelphia, was one of the first to demonstrate the effectiveness of radiation therapy in controlling residual tumor in the chest wall and lymph draining area. He recommended a combination of external beam and radium needle implant and his work was published in 1932.

In 1929, F. Baelesse,³ of the Foundation of Curie, used 180 KV x-ray machine as the sole method of treatment for locally advanced breast cancer. He found a complete tumor disappearance in 82% of his patients at one year.

More recently, Calle⁴ and his colleagues from the Foundation of Curie, reported the results of 120 patients with early breast cancer treated by lumpectomy and external beam radiation therapy. 5,000 rads were delivered to the entire breast and lymph draining area, and 1,500 rads were given as a boost to the excisional area. Sixteen patients, or 13%, had a local recurrence. Fourteen of these 16 local failure patients were treated by subsequent mastectomy, and eight of these patients were alive without disease at five years. Five- and ten-year absolute survival without evidence of disease was 85% and 75%, respectively.

Vera Peters,⁵ from Toronto, recently updated her experience by comparing 217 patients with T1 and T2 NO breast cancer treated by excisional biopsy and radiation therapy, with similarly staged patients treated by radical mastectomy with post-operative radiation. She found that the overall survival after 30 years was similar for both groups.

A recent series by Montague, et al,⁶ from M.D. Anderson Hospital, reported the results of 162 patients with Stage I and Stage II breast cancer treated by local excision and radiation therapy. She observed the local and regional failure rate was only 4.3% and overall recurrence-free survival was 85%.

SYED M. RAHMAN, M.D., Director of Radiation Oncology Service, Department of Radiology, Grant Hospital, Columbus, Ohio. Before coming to Columbus, Dr. Rahman was an assistant professor of therapeutic radiology, University of Virginia School of Medicine, Charlottesville, Virginia. He is certified by American Board of Radiology and has diploma in Medical Radiotherapy from the University of London, England.

JACK E. TETIRICK, M.D., Director of Medical Affairs, Grant Hospital, Columbus, Ohio.

OLLIE E. SOUTHARD, M.D., Senior Staff Radiologist, Grant Hospital, Columbus, Ohio.

GEORGE W. CALLENDINE, JR. Ph.D., Consultant Radiologic Physicist, Grant Hospital, Columbus, Ohio.

Prosnitz⁷ and his colleagues reported 150 patients with Stage I and II breast cancer from four institutions (Hahne-mann, Harvard Joint Center of Radiation Therapy, Jefferson, and Yale). All of these patients were treated uniformly by excisional biopsy of the primary tumor followed by radiation therapy. Radiation therapy principles and techniques were similar in the four institutions. 5,000 rads were delivered to the entire breast, either from a 4 Mev linear accelerator or a Cobalt 60 teletherapy unit. 1,000 to 2,000 rads then were given as a boost at the site of the excisional biopsy, either by the same external beam or by iridium 192 seed implantation. With a follow-up period from two to 14 years, Prosnitz⁷ found that the local and regional recurrence rate in these 150 treated patients was 6.6%. Overall survival figures were identical to those reported for similar early cases treated by surgery alone.

In August of 1980, Hellman, et al.,⁸ from Harvard JCRT, reported the early results of 176 patients with Stage I and II breast cancer treated by radiation therapy without mastectomy. Follow-up period for this series was 12 to 117 months with a median of 33 months. In 73 patients, external beam radiation was followed with an interstitial implant to the primary tumor area, using afterloading iridium seeds. Of 62 Stage I patients, there have been three local failures (5%); in 122 Stage II patients, there have been eight local failures (7%). The overall local recurrence rate in this series was 6%. Of 73 patients who had interstitial seed implantation over the excisional scar area, there was only one local recurrence (1.3%). The author predicted the cumulative local control in these implanted patients to be 98%, as compared to 89% for those not implanted.

The goal of excellent cosmetic result requires attention to several important principles. The treated breast should preserve normal volume and almost normal consistency and firmness. Surgical excision of the primary tumor and the application of radiation must be carefully delivered. Wide surgical excision should be avoided; only the palpable gross tumor should be removed. Megavoltage radiation should be utilized and one should carefully avoid overlapping beams, particularly during treatment of tangential breast ports and anterior, supraclavicular and axillary ports. No bolus should be used in early cases since relative skin sparing is important to achieve a better cosmetic result. No more than 5,000 rads with 200 rads

daily fraction should be given to the entire breast. Radiation dose by interstitial iridium 192 seed implantation should be 1,500 to 2,000 rads, depending on the completeness of excisional biopsy. Tissue compensator or wedge filter can be used to maximize the dose homogeneity in the entire breast area. In most of the recent series treated with modern radiation techniques, cosmetic results of the treated breast are excellent to good in over 97% of the cases.

Materials and Methods

At Grant Hospital Radiation Therapy Department, from January 1980, to May 1981, six patients with early breast cancer were treated by radiation therapy without mastectomy. The ages of these patients ranged from 31 to 72 years. In five patients, the histology of the tumor was infiltrating ductal carcinoma, and in one patient the histology was moderately differentiated scirrhous adenocarcinoma. The patients were referred for radiation therapy for a variety of reasons. Four of the patients refused mastectomy and wanted an alternative treatment. One patient had severe hypertensive heart disease and was not suitable for a surgical procedure. The surgeon advised against mastectomy in the sixth patient due to the presence of a palpable supraclavicular node. The diagnosis was established by excisional biopsy in four patients and segmental mastectomy in the remaining two. Axillary lymph node dissection was performed in only one patient (one of 15 nodes found to contain microscopic foci of metastatic carcinoma).

Staging included physical examination, chest x-ray, liver function tests, bone scan, metastatic skeletal series and liver-spleen scan. Staging system used was that of UICC which is a clinical staging system. In this system, Stage I tumor must be T1 NO; that is, the lesion is 2 cm or less, with no clinically palpable lymph node in the axilla. A Stage II lesion includes tumor greater than 2 cm but not larger than 5 cm with clinically involved axillary lymph nodes.

Co-60 Teletherapy

A Picker Model C-9 Co-60 teletherapy unit was used for the external irradiation. Treatment was given at 80 cm source-skin distance. The tumor-bearing area was treated to 5,000 rads in five fractions per week over a six- to six-and-a-half-week peri-

GRANT RADIATION ONCOLOGY CONSERVATIVE TREATMENT FOR CA BREAST

NAME	AGE	STAGE	BIOPSY	HISTOLOGY	EXTERNAL BEAM	BOOST BY IMPLANT	BOOST BY EXT. BEAM	CURRENT STATUS
K.S.	47	T1N0M0	EXC.	MOD. DIFF. SCIRRHOUS	5000	YES	NO	NED
B.D.	53	T1N0M0	EXC.	ADENO. CARCINOMA	over 6wks.	1500 rads		17 months
T.R.	72	T2N3M0	SEGMENTAL	INFILTRATING DUCTAL	5000	YES	NO	NED
C.R.	63	T2N0M0	MASTECTOMY	CA	over 6wks.	1600 rads	500 rads	16 months
M.J.	52	T2N0M0	EXC.	INFILTRATING DUCTAL	5000	NO	800 rads	11 months
J.S.	31	T2N1M0	EXC.	CA	over 6½wks.	NO		NED
		had	SEGMENTAL	INFILTRATING DUCTAL	5000	YES	NO	8 months
		axillary	MASTECTOMY	CA	over 6wks.	1200 rads	NO	NED
		dissect.			5000	NO	NO	5 months
		one node			over 6½wks.			NED
		(+)						2 months



Fig. 1 K.S. Forty-seven years old. Nylon tube containing radioactive Ir^{192} seeds are implanted through the area of cancerous tumor to allow a booster dose of internal radiation to destroy remaining cancer cells. Before this implant, tumor has been removed by local surgical excision or lumpectomy and the patient received thirty external radiation treatments delivered over the entire breast and lymph draining area as an outpatient.

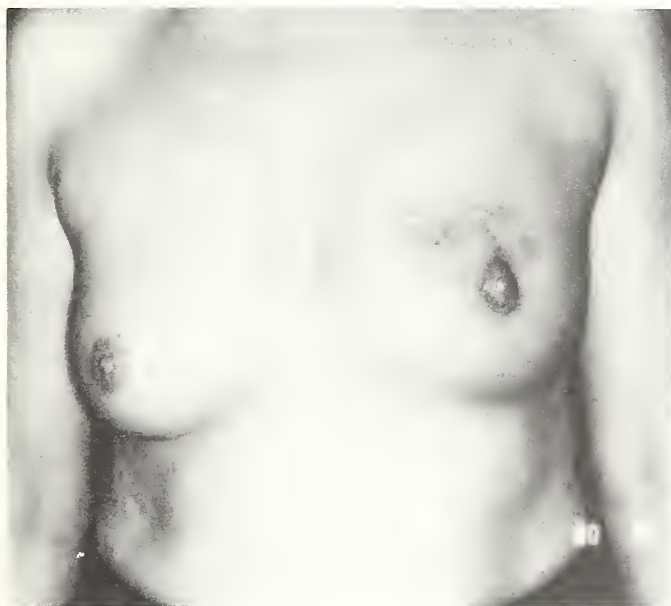


Fig. 2 K.S. One and a half years after the radiation treatment there is minimal pigmentation over the excisional scar.



Fig. 3 K.S. Lateral view one and a half years after radiation treatment.

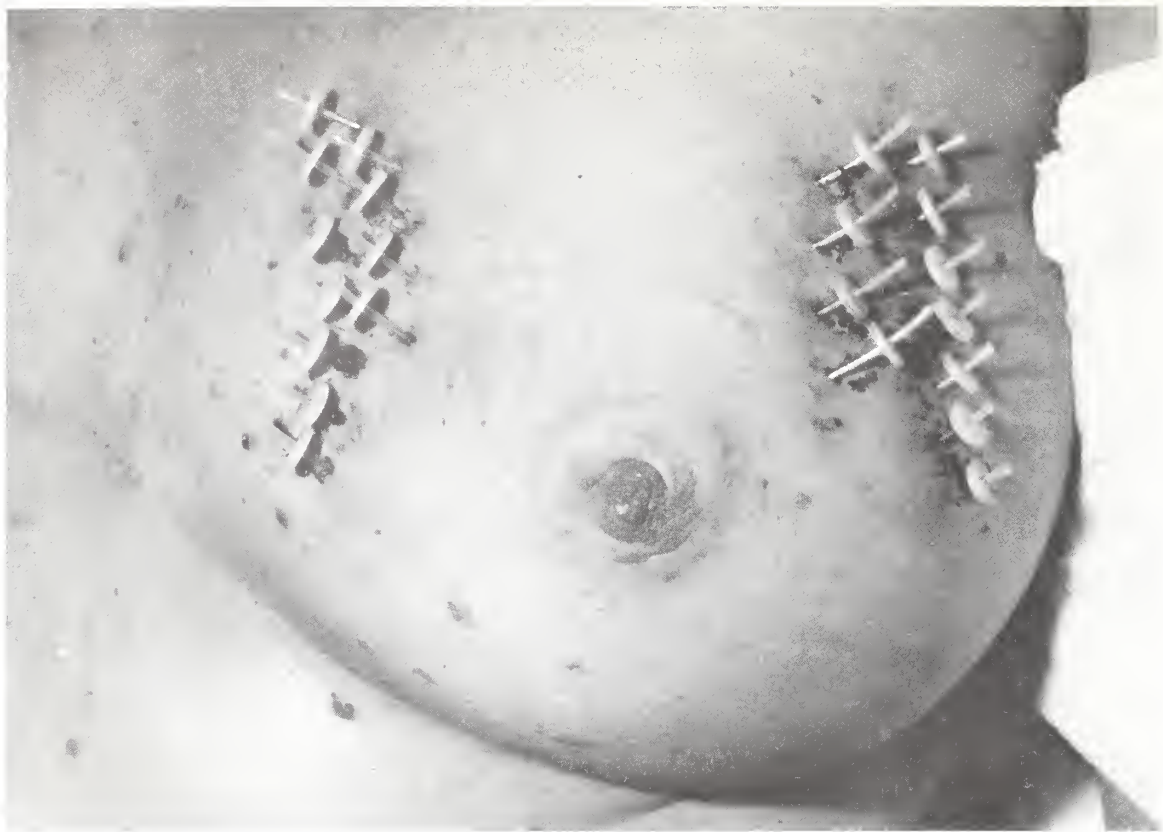


Fig. 4

M.J. Fifty-two years old. With radioactive Ir^{192} seed implant.



Fig. 5

M.J. One month after the complete treatment.

od. The entire breast was treated with parallel opposed medial and lateral tangential ports without bolus. The axilla and supraclavicular fossa were treated with direct parallel opposed anterior and posterior portals. The internal mammary lymph node chain was irradiated with a direct anterior portal to 5,000 rads at a depth of 3 cm. The adjacent margins of the fields were matched carefully. Beam portal films were taken to verify treatment areas. Depth dose curve matching and computerized dosimetry (utilizing the Memorial-Sloan Kettering Computer Dose Distribution System) techniques were used for dose assessment throughout the tumor-bearing region.

After 5,000 rads radiation dose had been given to the entire breast and lymph draining areas of all six patients, five patients received an additional boost dose of 500 to 1,600 rads at the site of excisional biopsy. This was given either by external beam therapy or by interstitial implant with iridium 192 seed. One patient who did not receive any boost dose of radiation had Stage II disease with a histologically positive axillary lymph node. She was seen by a medical oncologist and started multidrug systemic chemotherapy concomitantly with radiation treatment.

192 Iridium Implant Therapy

Three patients received additional boost treatment by iridium 192 seed implantation. The region to be implanted was determined jointly by the therapist and physicist. The type of implant was selected which would adapt best to the tumor and patient configuration (ie, single or multiple plane implant, uniform source spacing or uniform dose distribution, etc.). Iridium 192 ribbons (sources spaced in flexible nylon tubing) were ordered from the supplier.

Following preparation of the breast area under general anesthesia, the region of implant and entrance and exit points of each ribbon were marked on the skin with a sterile dye pen (ribbons were usually placed 1 cm apart and parallel). Sixteen-gauge stainless steel needles with stylettes were inserted at every ribbon position, entering and exiting the skin at the points previously marked. The stylettes were removed and nylon tubing inserted through the stainless steel needle, and then the stainless steel needle was removed. Lucite "buttons" were friction-fitted at both ends, leaving approximately 0.5 cm to the skin margin. The nylon tubing was then trimmed approximately 0.5 cm distal to each button.

The patients were taken to radiology following release from the recovery room, where the iridium 192 ribbons were positioned into the nylon tubes following the predetermined pattern. Tubing and ribbon ends were heat-sealed with a soldering iron. Orthogonal radiographs were taken and the dosage evaluated with the aid of computer dosimetry. The iridium 192 ribbons and nylon tubing were removed following administration of the appropriate tumor dose.

Discussion

There is reason to believe early breast cancer can be treated and controlled by radiation therapy without mastectomy. Postoperative radiation in chest wall and lymph draining area sterilizes the subclinical disease and is capable of preventing local recurrence. This form of therapy gives a superior cosmetic result with local and regional control rates equal to the results in the articles cited. Our personal experience is that full doses can be achieved with no serious side effects. The cases are being carefully followed.

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Coming in the March Journal

*The Malpractice Dragon . . . Is it rearing its head again?

A look at the recurring problem with malpractice. Is another crisis on the horizon?

*The Future of the Academic Health Science Center

*The OSMA Annual Meeting preliminary schedule

Ohio State Medical Association 1982 Budget Allocation (continued)

Ad Hoc: Long Range Plan	7,500.00	0	0	0
Committee: AMA-ERF	0	0	0	0
Committee: Art & Culture	0	0	0	0
Committee: Audit & Apprtn.	0	0	0	0
Committee: Cancer	0	0	750.00	0
Committee: Education	0	7,600.00	0	0
Committee: Emergency & Disas.	0	3,400.00	0	0
Committee: Cost Effective	0	0	0	0
Committee: Envirn. Liaison	0	0	250.00	0
Committee: Field Service	0	0	0	250.00
Committee: Govt. Med. Care	0	0	0	0
Committee: Health Manpower	0	0	2,000.00	0
Committee: Hlth. Planning	0	0	0	0
Committee: Hosp. Relations	0	0	0	0
Committee: Jails & Prison	0	0	0	0
Committee: Judicial/Prof.	600.00	0	0	0
Committee: Lab Medicine	0	0	0	0
Committee: Matrn/Neonatal	0	0	0	0
Committee: Members Ins.	0	0	0	0
Committee: Membership	0	0	0	0
Committee: Negotiations	0	0	0	0
Committee: Mental Health	0	0	4,500.00	0
Committee: Prof. Liab. Task	0	0	0	0
Committee: Communications	0	0	0	0
Committee: Rehabilitation	0	0	0	0
Committee: Scholarships	0	0	0	0
Committee: School Health	0	0	6,250.00	0
Committee: On Program	0	6,450.00	0	0
Committee: Special Educ.	0	0	500.00	0
Committee: State Legis.	0	0	0	0
Committee: Traffic Safety	0	0	200.00	0
Committee: Workmen's Comp.	0	0	0	0
Task Force: Hlth. Care Mkt.	0	0	0	10,000.00

All Departments

0	0	0	0	0	0	7,500.00
0	0	0	0	0	0	0
0	0	600.00	0	0	0	600.00
21,000.00	0	0	0	0	0	21,000.00
0	0	0	0	0	0	750.00
0	0	0	0	0	0	7,600.00
0	0	0	0	0	0	3,400.00
0	1,600.00	0	0	0	0	1,600.00
0	0	0	0	0	0	250.00
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0	0	0	0	0	0	2,000.00
0	1,900.00	0	0	0	0	1,900.00
0	0	0	0	0	0	0
0	0	0	0	250.00	0	250.00
0	0	0	0	0	0	600.00
0	0	0	0	0	0	0
0	1,800.00	0	0	0	0	1,800.00
0	0	0	300.00	0	0	300.00
0	3,000.00	0	0	0	0	3,000.00
0	0	0	0	0	0	0
0	0	0	0	0	0	4,500.00
0	0	0	500.00	0	0	500.00
0	0	800.00	0	0	0	800.00
0	0	0	0	0	0	0
0	0	0	0	0	0	0
0	0	0	0	0	0	6,250.00
0	0	0	0	0	0	6,450.00
0	0	0	0	0	0	500.00
0	0	0	0	3,000.00	0	3,000.00
0	0	0	0	0	0	200.00
0	0	0	0	0	0	0
0	0	0	0	0	0	10,000.00

Top medical developments for 1981

There have been a number of significant accomplishments in medicine over the past year, all of which rest on sound experimental research and years of investigation, according to James H. Sammons, M.D., Executive Vice President of the American Medical Association. Although it is difficult to draw arbitrary lines and say that a particular achievement in medicine happened on a particular day or month, the following advances would have to be listed as citing medical developments of 1981.

PET Scanner — Spawned from the CAT scanner, this second generation medical technology (PET: Positron emission tomography) allows us to witness — for the first time — whether or not actual cells are working as they are supposed to.

Hepatitis B Vaccine — The first entirely new viral vaccine to be

approved in ten years, this will be the first line of protection against a virus that infects as many as 300,000 Americans a year.

Lytic Enzyme Therapy — This still highly experimental treatment shows tremendous promise for preserving the heart muscle from further damage following a heart attack, or possibly even preventing a heart attack, by dissolving the clotted material where it clogs a coronary artery.

Hybridoma Technology — This technology has made possible the production of monoclonal antibodies, which can be thought of as akin to the targeted weapons of our immunological defenses. The advent of this technology has opened up new vistas in cancer detection and disease therapy, as well as added to our general understanding of the body's immune system.

Microsurgery — Techniques to join

blood vessels continue to expand, now into the brain.

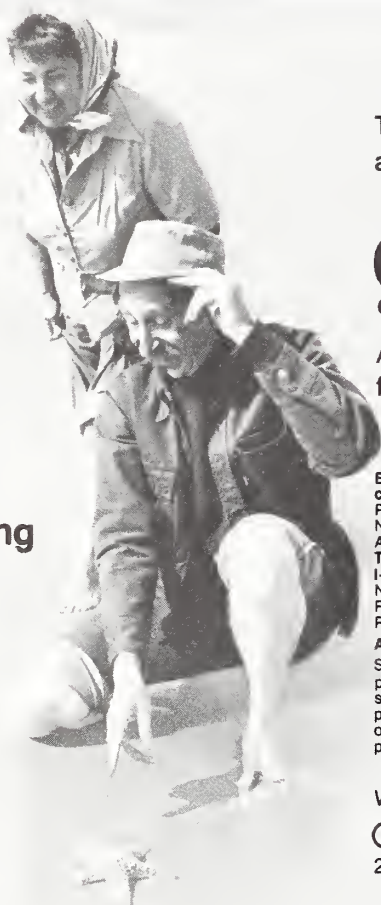
In-Utero Surgery — This year saw pioneering fetal surgery, the bold extension of the surgeon's skills into the womb for the treatment and correction of a number of disorders that threaten unborn babies.

Calcium Antagonists — A new direction for the treatment of certain heart beat irregularities and angina by drugs that influence calcium metabolism at the cellular level.

Beta-Lactams — These new, third generation antibiotics (penicillins were the first generation of beta-lactam antibiotics) have a wide spectrum of activity against gram-negative bacterial infections.

Beta-Blockers — This new line of drugs has sharply reduced the death rate among heart attack victims by significantly protecting against the recurrence of an attack.

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SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

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INDICATIONS: As a cerebral stimulant and vasodilator.

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WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

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recurrent anginal pain and reduced exercise tolerance associated with angina pectoris.

*Hannemann, R. E., Erb, R. J., Stoltman, W. P., Bronson, E. C., Williams, E. J., Long, R. A., Hull, J. H. and Starbuck, R. R.: Digital Plethysmography For Assessing Erythrityl Tetranitrate Bioavailability. Clin Pharmacol and Ther 29:35-39, 1981.

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CINCINNATI GROUP HEALTH ASSOCIATES, INC., a 27-member multi-specialty group practice is searching for a board-certified or eligible internist with subspecialty training in gastroenterology or cardiology to join our full-time staff. Our group offers an attractive compensation schedule, excellent fringe benefits, modern treatment facilities and the opportunity for stimulating professional interaction. Please forward your curriculum vitae to: Daniel J. Gahl, Assistant Administrator, Cincinnati Group Health Associates, Inc., 2915 Clifton Avenue, Cincinnati, Ohio 45220.

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GROUP PRACTICE IN NORTHERN OHIO has opening for general surgeon - board eligible - willing to do small amount of general practice. Small community near large metropolitan areas. Reply to Box No. 915, c/o Ohio State Medical Journal, 600 S. High Street, Columbus, Ohio 43215.

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Patient Medication Instruction

The American Medical Association is developing a Patient Medication Instructions (AMA-PMI) program through which written information about certain drugs will be made available to physicians for distribution, along with prescriptions, to their patients. The Association anticipates that the written information will reinforce the physician's oral instructions to the patient and will enhance consumers' knowledge about the drugs they are taking.

Initially, AMA-PMIs will be written for 10 of the most widely prescribed medications, both single entity drugs and combinations, and, in time, will cover 200 widely used drugs. For single entity drugs, the generic name will be the principal identifying designation and, whenever practical, the most widely known trade names will be included. The AMA-PMIs also will include common, documented side effects.

Plans call for the first group of AMA-PMIs to be available to physicians in the spring of 1982.



succeeds

in acute exacerbations of chronic bronchitis[†]

lowers the volume, clears the sputum

[†] Due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in the judgment of the physician Bactrim offers some advantage over the use of a single antimicrobial agent.

1. Rubin RH, Swartz MH. *N Engl J Med* 303:426-432, Aug 21, 1980

2. Data on file, Medical Department, Hoffmann-La Roche Inc.

In controlled multicenter studies involving *H. influenzae* and *S. pneumoniae*, a 7-day follow-up after 14-day treatment showed the causative organisms were eliminated in 50 of 55 patients (91%).² Five patients did not return for follow-up.

During therapy, maintain adequate fluid intake. Bactrim is contraindicated during pregnancy at term and lactation, in patients hypersensitive to its components, and in infants less than two months of age.

with B.I.D. convenience... **Bactrim™ DS**
(800 mg sulfamethoxazole and 160 mg trimethoprim)



Bactrim^{DS}

(800 mg sulfamethoxazole and 160 mg trimethoprim)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.

Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonia. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency, pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus, infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides.

Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended, therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. **CNS reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients, cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100, Tel-E-Dose[®] packages of 100, Prescription Paks of 20 and 28. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500, Tel-E-Dose[®] packages of 100; Prescription Paks of 40. Pediatric Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml), cherry-flavored—bottles of 100 ml and 16 oz (1 pint). Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1981 Subscription: \$15 per year, single copy \$2 (outside U.S. \$20 and \$3).

Send address changes to: The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second Class Postage paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioğlu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric, *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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SECOND OPINION

Foreign Medical Graduates

“We’re American doctors, too!”

By Felino V. Barnes, M.D.

Editor's Note

“Second Opinion” is a column of opinion, written by OSMA members and discussing important issues facing medicine today. The articles express the personal opinions of the authors and do not necessarily reflect official OSMA or JOURNAL policy. The JOURNAL encourages individual members to submit articles for this column. Preference will be given to short, concise articles which discuss the current issues of the day.

Lately Foreign Medical Graduates (FMGS) in the U.S.—and especially in Ohio—are feeling a sense of alienation. They feel that the time to speak up is now, and they are beginning to assert themselves, refusing to be capsulized in units of isolation any longer. Indeed they have contributed much to American medicine—especially at a time when they were badly needed. Whether they came from developing or developed countries, non-U.S. medical graduates arrived in the U.S. with a genuine taste for a challenge, competition, social and political growth and especially professional advancement as well as the economic enhancement

with an accent on the negative. Organized medicine has lately managed to select only the best FMGS with a variety of screening tests: the ECMFG, the FLEX, the VQE and now an AME proposal for FLEX 1 and 2 (which in my opinion U.S. graduates would fail).

Most FMGS in the country have not only contributed to the medical needs of the poor, to unserved areas, abandoned city ghettos, VA hospitals, mental institutions, prisons, and even the military, but also have contributed to local communities as leaders in education and politics.

This article has been written to lend some special significance to the role of

“Most FMGs in the country have not only contributed to the medical needs of the poor, to unserved areas . . . but also have contributed to local communities as leaders . . .”

which generally follows. Certainly they should not be faulted. The exodus of FMGS to the U.S. and Canada is simple to understand. They were needed. There were demands after World War II for research and so immigration policies had to be changed.

Organized medicine tends to downplay the role of the FMGS by resorting to statistics—unfortunately

FMGS and their contribution to AMERICAN ORGANIZED MEDICINE.

Felino V. Barnes is a director of the Cleveland Academy of Medicine, and director of Pediatrics, Deaconess Hospital of Cleveland and Southwest General Hospital. He also has served as a member of the N. Royalton Board of Education, three of those terms as president.



Letters ...to the editor

To the Editor:

The January issue of the OSMA Journal published an article ("Streamlining Your Office") by Linda N. Jesseph which contained some excellent information on how to improve the business aspects of a medical practice. Ms. Jesseph, however, made one statement which may not be correct in all instances. She states that "It is advisable that every insurance transaction be made with payment sent directly to you, the provider." The reason for this, according to Ms. Jesseph, is too often funds are sent to the patient, spent by the patient, and the physician never receives remuneration for his or her service.

This statement suggests that every physician should take assignment under every circumstance. However, there may be instances in which this may not be advisable. For example: If a physician accepts Medicare assignment, the physician may only bill the patient a remaining balance of his fee not to exceed the allowable amount permitted by Medicare.

By not accepting assignment and direct payment from Medicare, the physician is permitted to bill the patient any remaining balance of his fee not paid by Medicare.

In addition, if Medicare assignment is taken, and a patient is enrolled in a private insurance program designed to supplement the deductibles and co-insurance provisions of Medicare, the private insurance carrier must limit benefit settlement to the Medicare allowable, thus disregarding the physician's actual fee for his services.

There are many methods to streamline the business aspects of a medical practice, and Ms. Jesseph has provided some excellent suggestions. However, each medical practice is different, and physicians should decide which method of collection is best for their individual type of medical practice.

/S/ C. Douglass Ford
Toledo
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HOMER ANDERSON, M.D., Columbus, was reelected president of the board of trustees of the Medical Bureau and **JAMES MATSON, M.D.**, Columbus, was elected secretary-treasurer.

GORDON BORKAT, M.D., Lakewood, was named chairman of Fairview General Hospital's department of pediatrics.

CHARLES M. BRANDEN, M.D., was elected president of the Marymount Hospital medical staff and chairman of the Medical Executive Committee. Dr. Branden is an assistant clinical professor of the department of reproductive biology at Case Western Reserve University School of Medicine.

Other officers elected include: **JOHN G. MARGRETT, M.D.**, president-elect of the medical staff and chairman of the medical council; **GARY A. KLEINMAN, M.D.**, secretary of the medical staff; and **WILLIAM E. BRUCK, M.D.**, treasurer of the medical staff.

DUDLEY F. BRIGGS, M.D., Columbus, was elected to the board of directors of the American Occupational Medical Association. Dr. Briggs is on the medical staff of Mt. Carmel Hospital.

ROLAND D. CARLSON, M.D., Pepper Pike, was elected chief of staff of Huron Road Hospital. Dr. Carlson is an ophthalmologist.

MICHAEL J. CASALE, M.D., Warren, was elected president of St. Joseph Hospital medical staff. Dr. Casale is a specialist in obstetrics and gynecology and has been on the hospital staff since 1965. Also elected were **C.H. CHUNG, M.D.**, a urologist, on the staff since 1971, vice-president, and **FERMIN T. YU, M.D.**, a general surgeon at the hospital since 1970, secretary-treasurer.

HERBERT DERMAN, M.D., Columbus, was elected vice-president of the College of American Pathologists. Dr. Derman is director of pathology at Riverside Methodist Hospital and clinical professor of pathology, Ohio State University College of Medicine.

J. MICHAEL DOLIBOIS, M.D., Hamilton, was named chief of the medical and dental staff at Mercy Hospital North. Dr. Dolibois is an orthopedic surgeon.

The following were elected officers of the Northern Columbiana County Community Hospital medical staff: **D. W. DRAKE, D.O.**, Salem, secretary; **J.R. MADISON, M.D.**, Salem, treasurer; and **W.A. BACON, M.D.**, Lisbon, chief of staff.

KENNETH A. FREDERICK, M.D., Cincinnati, was appointed to the Commission on Legislation and Governmental Affairs of the American Academy of Family Physicians.

The following were elected officers of the Lake County Memorial Hospital medical staff: **JOSEPH GOLDBERG, M.D.**, Mentor, president; **JOHN A. BUKOVNIK, M.D.**, Willoughby, vice-president; and **BERNARD ENDRES, M.D.**, Mentor, secretary-treasurer.

TOM DUNBAR HALLIDAY, M.D., Marietta, was elected vice-chairman of the Ohio Section of the American College of Obstetricians and Gynecologists. Dr. Halliday is in private practice and is vice-chairman of the plan development committee at Area VI Health Systems Agency.

HARRY W. HAVERLAND, M.D., Steubenville, was elected president of the Ohio Valley Hospital medical staff. Dr. Haverland is a pathologist. Also elected were **JOSEPH AGRESTA, M.D.**, president-elect, and **NANCY BRIGHT, M.D.**, secretary-treasurer.

ROBERT M. KAPPERS, M.D., Hamilton, was elected chief of staff at Fort Hamilton-Hughes Hospital. **GEORGE MANITSAS, M.D.**, was elected chief of staff-elect and **JOHN EVANS, M.D.**, was elected secretary.

RALPH LACH, M.D., Columbus, was recognized as one of two Alumni Medalists at John Carroll University in Cleveland and a scholarship fund endowment has been established at the University in Dr. Lach's name. Dr. Lach is director of cardiology at Mt. Carmel Hospital.

DONALD W. LENHART, M.D., Sandusky, was reelected president of the medical staff of Providence Hospital. Dr. Lenhart is a general surgeon and serves on the hospital planning committee and its board of trustees. **K.H. KIM, M.D.**, Sandusky, was reelected secretary-treasurer. Dr. Kim is chief of the division of urology.

WILLIAM F. NICHOLS, M.D., was named president, **MEHENDRA PATEL, M.D.**, vice-president, and **GABRIEL A. SABGA, M.D.**, secretary, of the medical staff at Elyria Memorial Hospital.

JAMES ORR, M.D., Gallipolis, was elected president of the Dr. Samuel L. Bossard Memorial Library Board. Dr. Orr previously served as vice-president of the board and has been a member of the board for 13 years.

The following were elected officers of the Lake County Medical Society: **DONALD PATCHIN, M.D.**, Mentor, president; **RONALD POSNER, M.D.**, Mentor, vice-president; and **RICHARD TOOMEY, M.D.**, Willoughby, secretary-treasurer.

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Inderal® BRAND OF propranolol hydrochloride A beta-adrenergic blocking agent

BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

CONTRAINDICATIONS

INDERAL is contraindicated in 1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta-blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. INDERAL acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by INDERAL's negative inotropic effect. The effects of INDERAL and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during INDERAL therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, INDERAL therapy should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of INDERAL therapy. Therefore, when discontinuation of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS DURING ANESTHESIA with agents that require catecholamine release for maintenance of adequate cardiac function, beta blockade will impair the desired inotropic effect. Therefore, INDERAL should be titrated carefully when administered for arrhythmias occurring during anesthesia.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, INDERAL should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since INDERAL is a competitive inhibitor of beta receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA: Because of its beta-adrenergic blocking activity, INDERAL may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY: The safe use of INDERAL in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit.

Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of INDERAL may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block; hypotension, paresthesia of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Miscellaneous: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

ORAL

DOSEAGE AND ADMINISTRATION

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 40 mg INDERAL twice daily, whether used alone or added to a diuretic. Dosage may be increased gradually until adequate blood pressure is achieved. The usual dosage is 160 to 480 mg per day. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

While twice-daily dosing is effective and can maintain a reduction in blood pressure throughout the day, some patients, especially when lower doses are used, may experience a modest rise in blood pressure toward the end of the 12 hour dosing interval. This can be evaluated by measuring blood pressure near the end of the dosing interval to determine whether satisfactory control is being maintained throughout the day. If control is not adequate, a larger dose, or 3 times daily therapy may achieve better control.

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

INTRAVENOUS

The intravenous administration of INDERAL has not been evaluated adequately in the management of hypertensive emergencies.

OVERDOSAGE OR EXAGGERATED RESPONSE

IN THE EVENT OF OVERDOSAGE OR EXAGGERATED RESPONSE, THE FOLLOWING MEASURES SHOULD BE EMPLOYED:

BRADYCARDIA—ADMINISTER ATROPINE (0.25 to 1.0 mg): IF THERE IS NO RESPONSE TO VAGAL BLOCKADE, ADMINISTER ISOPROTERENOL CAUTIOUSLY.

CARDIAC FAILURE—DIGITALIZATION AND DIURETICS.

HYPOTENSION—VASOPRESSORS, e.g., LEVATERENOL OR EPINEPHRINE (THERE IS EVIDENCE THAT EPINEPHRINE IS THE DRUG OF CHOICE).

BRONCHOSPASM—ADMINISTER ISOPROTERENOL AND AMINOPHYLLINE.

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No. 468—Each scored tablet contains 80 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

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The Future of the Academic Health Science Center

By Robert S. Daniels, M.D.

The purpose of this communication is to comment upon possible influences and trends for academic health science centers for the next five to ten years. The focus will be mainly on colleges of medicine, although many of the circumstances also affect other educational professional and technical units.

The major trends in national social health policy until recently have been in the direction of the following special objectives:

1. Increasing the number of physicians.
2. Improved ambulatory or primary care.
3. Improved service to underserved areas and populations, especially inner city and rural areas.
4. Rational planning for the health care system.
5. Control of health care expenditures by the regulation of capital developments and new clinical programs.
6. Control of overutilization of health care.
7. Improved reimbursement for certain types of care.

More recently (since January 1981) there is a changed political economic philosophy, sometimes called "supply side economics," which favors decreasing taxes in the hope that personal and corporate savings will be increased and applied to capital plant improvement and mechanisms to increase productivity. By these means, the gross national product is to be increased at a more rapid rate and it is hoped that the inflation rate will fall.

There is also emphasis on a reduced level of regulation and on increased competitiveness.

For example, as applied to the medical care system, there would be less regulation of hospital rates, professional fee reimbursement, and capital investments. Planning in the regulatory sense would be less emphasized. Competition would be encouraged, with various medical care entities competing for who could deliver the most service at the least cost. In education, it would require students to be less dependent on public subsidies for the cost of their education.

Other important influences are:

1. A perception that we are training too many physicians and that we may have surpluses by 1990.
2. Decreased federal support for a number of health educational programs.
3. Continuing evaluation of insurance programs for health and illness care, with more careful scrutiny about the extent and the length of support.
4. Emphasis on research in cancer, cardiovascular disease, environmental problems, etc.

PLANNING AND REGULATION

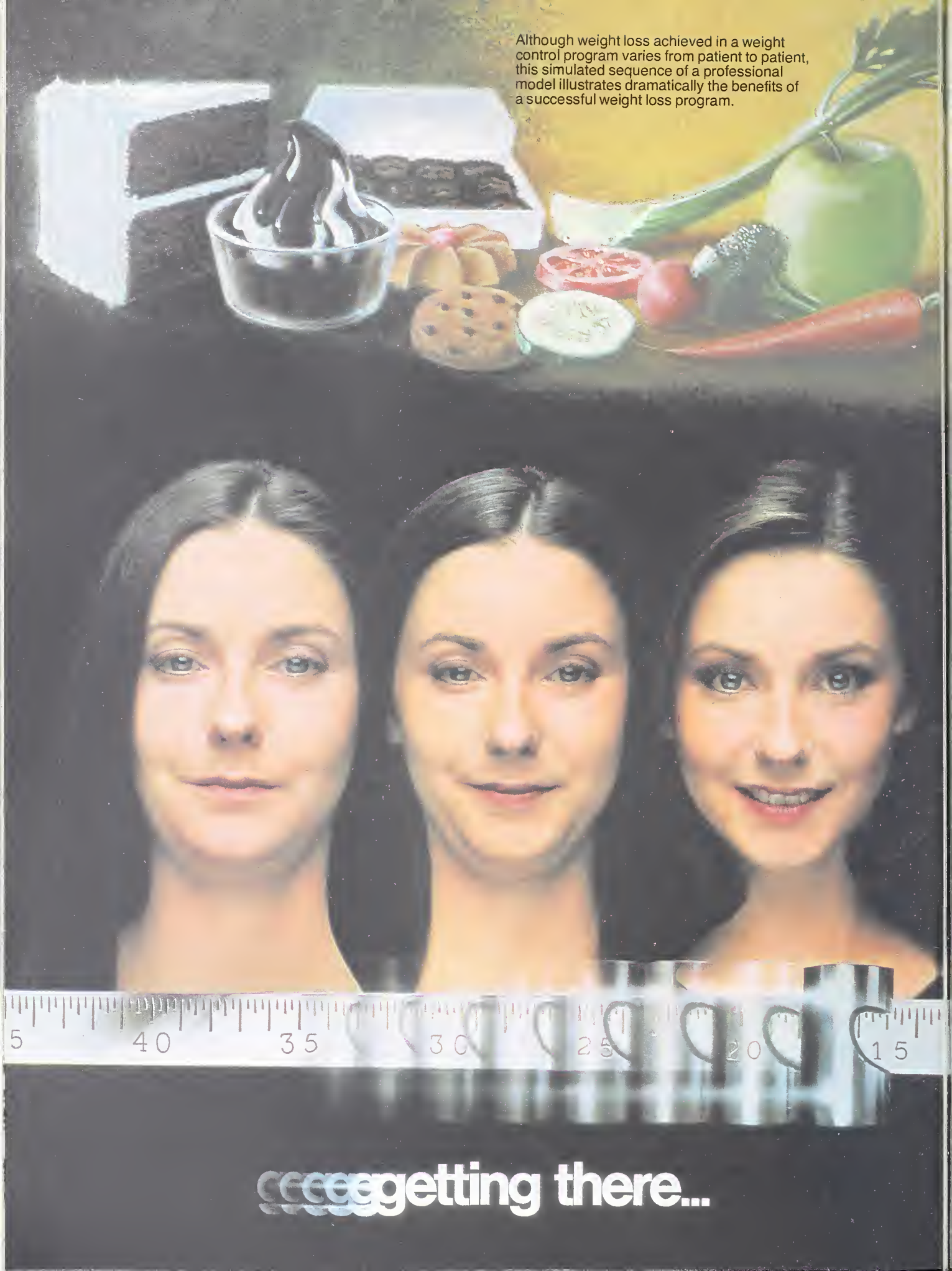
The approaches to planning and regulation usually establish an ideal system through a politically negotiated and adopted model plan, either developed through centralized or decentralized mechanisms. The centralized approach is followed

throughout most of the rest of the developed world. Typically, such a system has one or several mechanisms for ambulatory care which are organized usually with a capitation or salaried payment for the physician. Hospital care is organized in successively more specialized tiers, usually with a single central tertiary care hospital for a district or a region, also often used as the principal teaching hospital and as a center for research.

Parts of this model do not fit well with American philosophical, social, political and governmental approaches. The American model is an openly competitive free enterprise system in which there has been relatively little regulation and relatively fewer controls. The major difficulties with this model being effective in this country are the methods of reimbursement third-party payments to the hospitals, largely determined by costs; and, fee-for-service professional fee reimbursement in which the professional decides what services are to be rendered and what fees are to be charged.

However, the regulation of the medical care system has been increasing substantially year by year — largely through reimbursement mechanisms and in planning new facilities and services. Of course, difficulties arise out of the complexities of trying to encourage a competitive system, based on free enterprise on the one hand and a regulated and controlled system on the other. Either alternative would be simpler. The

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Comparison of Anorectics

	Agent	Amine Classification	Half-life ^a	Variety of Dosage Form	Degree of CNS Effects
Low Abuse Potential	Diethylpropion	Tertiary	4-6 hrs.	25 mg tablet, 75 mg controlled-release tablet	Mild euphoria, mild stimulation
	Mazindol	Nonphenylethyl-amine	33-55 hrs.	1 & 2 mg tablet	Mild euphoria, mild stimulation
	Fenfluramine	Secondary	10-30 hrs.	20 mg tablet	Moderate sedation (mild to moderate depression, a side effect, is also sometimes designated as a CNS effect)
	Phentermine	Primary	19-24 hrs.	8 & 37.5 mg tablet, 8, 15 & 30 mg capsule 15 & 30 mg capsule (resin complex) 15 & 30 mg timed release capsule	Mild euphoria, moderate stimulation
High Abuse Potential	Phenmetrazine	Secondary	7-9 hrs.	25 mg tablet, 50 & 75 mg prolonged action tablet	Marked euphoria, marked stimulation
	Amphetamine	Primary	10-30 hrs.	Various	Marked euphoria, marked stimulation

^aDelayed release characteristics of certain dosage forms must also be taken into account.

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Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly. When central nervous system active agents are used, consideration must always be given to the possibility of adverse interactions with alcohol. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression, changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSEAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride) One 25 mg tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release. One 75 mg tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of June, 1980

Reference: 1. Abramson R, Garg M, Cioffari A, and Rotman PA, An Evaluation of Behavioral Techniques Reinforced with an Anorectic Drug in a Double-Blind Weight Loss Study. *J Clin Psych* 41: 234-237, 1980

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combination is very complex and difficult.

As the new approaches to some of these questions emerge, it seems that total public cost will be controlled by caps or ceilings in expenditures. There also will be reductions in the amounts of money made available by the federal government. The money from many programs will be combined and will be conveyed to the states by block grants. The states then will have the authority and the responsibility to decide which programs will be supported and to what extent. States will almost certainly be experimenting with various kinds of contracts with health care agencies. These arrangements will place the medical care system under very great stress and almost certainly there will be reductions in the quantity and quality of services.

THE INFLUENCE OF CHANGING POPULATION COMPOSITION AND STATE GOVERNMENT

Population changes will influence state and local expectations of academic health science centers. In the Northeast and the Middle West, for example, little if any growth in population is anticipated and there will be a gradually aging population. That situation is likely to be quite different from other areas, for example the Sun Belt in which the population growth is rapid and is likely to be composed of both the very young and the very old.

Local academic health science centers will relate to these population shifts and will evaluate and analyze personnel needs so that over long-time perspectives the right numbers and composition of professionals are available to carry out the patient care and health maintenance needs of the populations that require service. This matter is particularly complex in this country because we have not clearly decided how we shall organize medical care; which professional groups will deliver which services and how the services will be paid for. We also have great individual freedom about where we settle and the varieties of professional practices in which we engage.

THE INFLUENCE OF SOCIOPOLITICAL FACTORS ON EDUCATIONAL INSTITUTIONS INCLUDING ACADEMIC HEALTH CENTERS

There will be sharp decreases in the number of students reaching college age in the next decade. University student bodies are likely to decrease in size. This decrease in the number of students will likely influence national and state policy to provide less support for higher education and perhaps also for the education of health professionals, especially physicians. Stating it differently, physicians are likely to be a good deal less precious, and valued less highly.

At the same time some colleges within a particular university may not decrease in size or may even expand. An example of this situation is likely to be in some colleges in the academic health centers. Although most observers now believe that we have enough medical students when the current national expansion is complete, nursing and technical educational programs are likely to increase in numbers since the public need for more of these personnel continues to be high.

Another serious educational pressure is likely to result from the reductions in public support for student loans and scholarships. The changes in support may well make it increasingly difficult for poor to middle income families to support higher education. This difficulty is also often combined with markedly increased tuition costs which in turn are a consequence of the inflation and decreased support for the universities, particularly from the federal government. This increase, along with reduced scholarship and loan availability, may result in "ability to pay" becoming an admission criterion for the first time in American medical colleges since the 1930s.

A crucial issue then will be how federal, state and local government and the local university and the academic health center will manage this paradoxical situation in which one government is decreasing while the other may be constant or increasing.

THE INFLUENCES ON MANPOWER

The major personnel shortages in American medicine are probably a consequence of two major factors: (1) too few professional and technical persons in primary medical and health care and their maldistribution, and (2) the organization and finance of medical care services. For almost 30 years after World War II, the major influences in American medical and health care were in the direction of increasing specialization in highly technical scientific areas, a time of specialization. As a consequence, there were fewer professionals who entered careers in first line ambulatory care and shortages developed, especially in rural areas and in urban poverty areas. There were also shortages which developed in several medical specialties, including anesthesia, pathology, psychiatry, and others.

Society, through its institutions and political structures, reacted in a number of ways to these developments. Beginning in the mid '60s, there was an increase in the number of colleges of medicine and expansions of existing colleges. There have been conscious and dedicated attempts to increase the number of minorities and women, as well as to improve the primary care manpower situation by developing departments of family medicine and by expanding and improving programs in general internal medicine and general pediatrics.

Nurse education and nursing services have also changed. World War II served as a catalyst for improved patterns of nursing education and increased demand for professional nursing services in a variety of institutional and public health settings.

The rapid advances in scientific knowledge and technology combined with the rapid growth of schools of nurse education necessitated further educational preparation for nurses who would specialize in selected clinical areas and for nurses who would become instructional faculty.

Pharmacy also is expanding its role and there is also a trend toward increasing specialization. Allied health, technical, and professional education is diversified and becoming specialized

as well. Although basically the functions of all these professions are clear, at the margins there is a great deal of interaction and some conflict about what preparation is necessary to deliver what services to what populations. These questions are complicated by interactions about reimbursement and who will receive what moneys under what conditions of practice.

THE INFLUENCE OF SOCIOPOLITICAL FACTORS ON RESEARCH

The capacity for an institution, such as an academic health center, to support its own research is very limited and will largely involve pilot or start-up projects or bridging moneys between grants. The best or most likely source of such moneys is clinical practice income converted to academic uses. The institution, though, is very important in providing good quality

organizational support and space. It is also important in providing certain research support facilities such as animal care space and libraries.

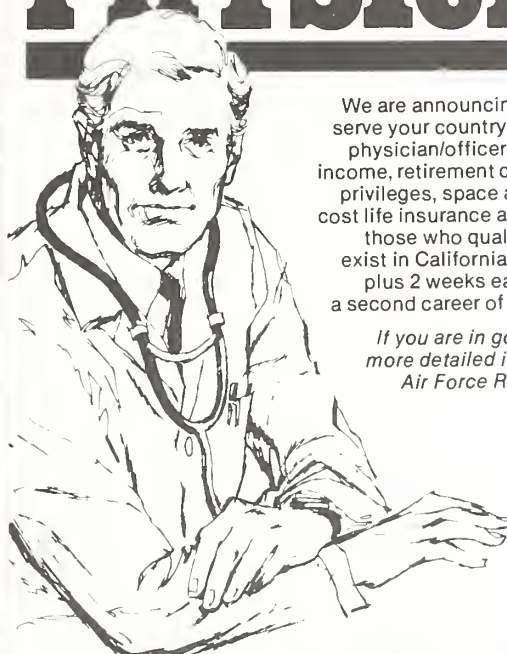
The content areas of research such as cancer, cardiovascular disease, environmental research, and diseases of aging, are likely to continue to be important. The public need tends to be defined by problems, by age definition, and by disease category.

THE INFLUENCE OF SOCIOPOLITICAL FACTORS ON PATIENT CARE

A combination of social and political forces will result in increasing emphasis on two levels of patient care in most academic medical centers. First is ambulatory or primary care; the second is highly complex technical, hospital care or tertiary care. This combination is both interesting and difficult to interrelate because they

(continued on page 177)

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Initial therapy with modest salt restriction and a diuretic alone will control about 40% of all hypertensives.¹ For the other patients with essential hypertension, an additional drug is needed to reduce blood pressure below 90 mm Hg.

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The two components of **INDERIDE**—propranolol HCl and hydrochlorothiazide—complement each other and may allow lower dosage to help keep side effects to a minimum and encourage long-term compliance as well as control.

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Each tablet contains **INDERAL[®]**
(propranolol HCl), 40 mg or 80 mg,
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AVAILABLE STRENGTHS:

40/25

80/25

Please see brief summary of prescribing information on following page.

*As with all fixed combinations, **INDERIDE** is not indicated for initial therapy of hypertension and should not be used in dosage which would provide more than 100 mg hydrochlorothiazide per day.

BRIEF SUMMARY
(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)

INDERIDE®

BRAND OF
propranolol hydrochloride
(INDERAL®)
and hydrochlorothiazide

No. 474—Each IINDERIDE®-40/25 tablet contains.	40 mg
Propranolol hydrochloride (INDERAL®)	25 mg
Hydrochlorothiazide	
No. 476—Each IINDERIDE®-80/25 tablet contains	.80 mg
Propranolol hydrochloride (INDERAL®)	
Hydrochlorothiazide	25 mg

WARNING: This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

DESCRIPTION: IINDERIDE combines two antihypertensive agents, IINDERAL (propranolol hydrochloride), a beta-adrenergic blocking agent, and hydrochlorothiazide, a thiazide diuretic-antihypertensive.

INDICATION: IINDERIDE is indicated in the management of hypertension. (See boxed warning.)

CONTRAINDICATIONS: Propranolol hydrochloride (INDERAL®): Propranolol hydrochloride is contraindicated in 1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS: Propranolol hydrochloride (INDERAL®): **CARDIAC FAILURE:** Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE: continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn, b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS: there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS: possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME: several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY: beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOLYCEMIA: Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

USE IN PREGNANCY: Propranolol hydrochloride (INDERAL®): The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

Hydrochlorothiazide: Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers: Thiazides appear in breast milk. If the use of the drug is deemed essential, the patient should stop nursing.

PRECAUTIONS: Propranolol hydrochloride (INDERAL®): Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause are: dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements such as foods with a high potassium content.

Any chloride deficit is generally mild, and usually does not require specific treatment except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

ADVERSE REACTIONS: Propranolol hydrochloride (INDERAL®): Cardiovascular: bradycardia, congestive heart failure, intensification of AV block; hypotension; paresthesia of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometric tests.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Miscellaneous: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

Hydrochlorothiazide: **Gastrointestinal:** anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

Central Nervous System: dizziness, vertigo, paresthesias, headache, xanthopsia.

Hematologic: leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular: orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: purpura, photosensitivity, rash, urticaria, necrotizing angitis (vasculitis, cutaneous vasculitis), fever, respiratory distress including pneumonitis, anaphylactic reactions.

Other: hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

DOSEAGE AND ADMINISTRATION: The dosage must be determined by individual titration (see boxed warning).

Hydrochlorothiazide is usually given at a dose of 50 to 100 mg per day. The initial dose of propranolol is 40 mg twice daily and it may be increased gradually until optimum blood pressure control is achieved. The usual effective dose is 160 to 480 mg per day.

One to two IINDERIDE tablets twice daily can be used to administer up to 320 mg of propranolol and 100 mg of hydrochlorothiazide. For doses of propranolol greater than 320 mg, the combination products are not appropriate because their use would lead to an excessive dose of the thiazide component.

When necessary, another antihypertensive agent may be added gradually beginning with 50 percent of the usual recommended starting dose to avoid an excessive fall in blood pressure.

OVERDOSEAGE OR EXAGGERATED RESPONSE: The propranolol hydrochloride (INDERAL®) component may cause bradycardia, cardiac failure, hypotension, or bronchospasm.

The hydrochlorothiazide component can be expected to cause diuresis. Lethargy of varying degree may appear and may progress to coma within a few hours, with minimal depression of respiration and cardiovascular function, and in the absence of significant serum electrolyte changes or dehydration. The mechanism of central nervous system depression with thiazide overdosage is unknown. Gastrointestinal irritation and hypermotility can occur; temporary elevation of BUN has been reported, and serum electrolyte changes could occur, especially in patients with impairment of renal function.

TREATMENT: The following measures should be employed: **GENERAL:**—If ingestion is, or may have been, recent, evacuate gastric contents taking care to prevent pulmonary aspiration. **BRADYCARDIA:**—Administer atropine (0.25 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously. **CARDIAC FAILURE:**—Digitalization and diuretics. **HYPOTENSION:**—Vasopressors, e.g., levaterenol or epinephrine. **BRONCHOSPASM:**—Administer isoproterenol and aminophylline. **STUPOR OR COMA:**—Administer supportive therapy as clinically warranted. **GASTROINTESTINAL EFFECTS:**—Though usually of short duration, these may require symptomatic treatment. **ABNORMALITIES IN BUN AND/OR SERUM ELECTROLYTES:**—Monitor serum electrolyte levels and renal function; institute supportive measures as required individually to maintain hydration, electrolyte balance, respiration, and cardiovascular renal function.

HOW SUPPLIED: No. 474—Each IINDERIDE®-40/25 tablet contains 40 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 476—Each IINDERIDE®-80/25 tablet contains 80 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100.

References: 1) Kaplan, N. M. Beta-blockade in the treatment of mild to moderate hypertension, in Braunwald, E. (ed.) Beta-Adrenergic Blockade, A New Era in Cardiovascular Medicine, Amsterdam, Excerpta Medica, 1978, pp. 253-263. 2) Veterans Administration Cooperative Study Group on Antihypertensive Agents. J A M A. 237: 2303 (May 23) 1977.

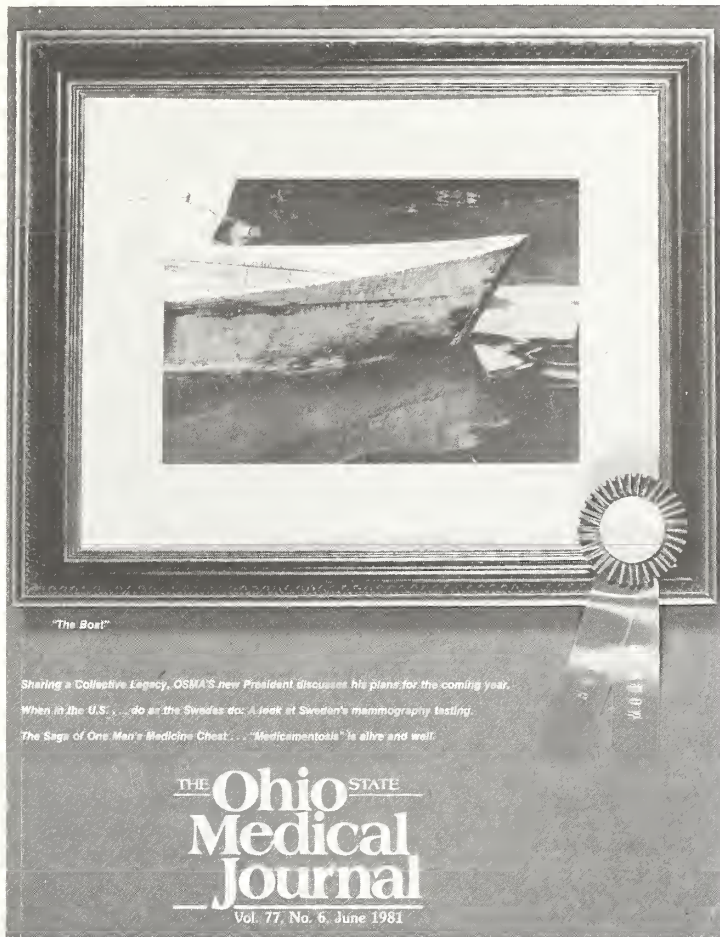
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The 1982

Ohio State Medical Journal

Photographic Exhibit



The Ohio State Medical Journal is sponsoring its fifth annual photographic exhibit and competition. The 1982 competition is open to both physicians and spouses. Persons submitting winning entries will receive awards at the 1982 Annual Meeting, Dayton, where the entries will be displayed.

Photographs may be entered in two divisions: Black and White, and Color. Each division has two categories: General and Scientific.

Entries must be in print form (8" x 10" or 11" x 14") in size) and mounted on print board, or otherwise for ease of display on a peg board. Photographs placed under glass will not be accepted. All entries submitted must be previously unpublished, and right to publish the photograph must be given to the Journal at the time the photograph is entered in the exhibit.

An OSMA member or spouse may submit as many entries as he/she wishes. Each photo must be accompanied by an entry form and a \$10.00 entry fee. If mailed, please be certain photograph is securely wrapped to avoid possible damage.

ENTRY FORM

Name _____
 If Nonmember, Spouse's Name _____
 Street _____
 City _____ State _____
 County _____ Zip _____
 Telephone _____

Information about photograph:
 (provide as much as possible)

Camera _____ Lens _____
 Speed _____ Aperture _____
 Subject _____ Film Type _____
 Date _____ Time of Day _____
 Title _____

Division: ☐ B & W ☐ Color
 Category: ☐ General ☐ Scientific
 Processing/Printing:
☐ Professional ☐ Self

Mail or hand carry the photograph, entry form and \$10 entry fee (make checks payable to The Ohio State Medical Journal) to: The Ohio State Medical Journal Photographic Exhibit, 600 S. High Street, Columbus, Ohio 43215. All entries must be received no later than March 26, 1982.

I give the *Journal* publication rights to this photograph. I certify that this photograph has not been published previously and that I will not submit it for publication elsewhere pending the judging of the photographic exhibit. Also, I certify that any person(s) pictured have given me authorization to allow publication of his/her photograph. I also understand that if my photograph is selected for a Journal cover, it may be cropped to meet printing specifications.

Signature _____

NEWS

A compilation of the latest developments, trends and priorities of interest to physicians.

Wanted: Poets

Physician-poets and their spouses are urged to submit their creative works to the Ohio State Medical Association's (OSMA) Art and Culture Committee Chairman, Harry Fox, M.D., Cincinnati, for possible publication in the Ohio State Medical Journal. Send your poetry to Dr. Fox at: 368 Doctors Building, 19 W. Eighth, Cincinnati, Ohio 45202.

The Art and Culture Committee also will be sponsoring an exhibit of Latin-American Art, from the collection of Jack Singer, M.D., during this year's OSMA Annual Meeting. Dr. Fox would be interested in hearing from other physician-members who might also have a collection of Latin-American art, and may be contacted at the address given above.

An added feature at the exhibit will be taped music, performed by physician-members and their spouses, which the Committee has arranged to be played in the background during exhibition hours.

The exhibit will be held at Stouffer's Dayton Plaza Hotel. Be sure to include it in your Annual Meeting Schedule.

Why combination therapy works

Research on the diverse nature of cancer cells, being done at a number of centers, suggests that it is the differences among the cells in a cancer that make it more susceptible to combination therapy, involving radiation and drugs or combinations of drugs, rather than the single therapy approach.

But the differences among the cells also may account for why similar-appearing cancers don't always respond the same to therapy.

According to a recent report in the *Journal of the American Medical Association*, researchers have found single cancers comprised of cells differing in their secretory products, in their sensitivity to hormones, and in their genetic characteristics.

Albert H. Owens, Jr., M.D., head of the Johns Hopkins Oncology Center in Baltimore, Md., says, "It is becoming apparent that tumor cells which look

alike when stained and viewed under a microscope, do not necessarily behave alike in the body."

Some of these cells, he said, may break away from the main portion of the cancer to seed other areas of the body with cancer, while other cells in the same tumor may not share this tendency to metastasize. Some may divide, others not. Some may be sensitive to drugs, others may be resistant.

It may be that such heterogeneity is the common denominator in cancer, as Paul Calabresi, M.D., of Roger Williams General Hospital in Providence, R.I., noted.

Five years ago, few, if any, researchers seriously considered that a single cancer could contain mixtures of cell types. Now the existence of such heterogeneity is being used as a basis for treatment and prognosis.

National Trauma Resource Center established

Formation of the National Trauma Resource Center (NTRC), a "clearing house" for trauma research and education projects, was announced recently at the national Trauma Care symposium.

The organization will have headquarters in Phoenix with satellite offices in regional population centers nationwide.

The NTRC will produce teaching aids, training materials and films, create a national directory to link trauma centers with top specialists and develop seminars and exhibits to foster cooperation between health care professionals and the public.

Additional information on the National Trauma Resource Center can be secured by contacting NTRC, 9211 North 2nd Street, Phoenix, AZ 85020 or calling (602) 861-1453.



Dr. Zollinger in JAMA

It may be a long way from a "C" in surgery to the professorship of what has been called "one of America's best-known surgical units," but Robert M. Zollinger, M.D., Columbus — Professor and Chairman Emeritus, Department of Surgery, Ohio State University — has weathered the trip well. Dr. Zollinger was recently profiled in an issue of the *Journal of the American Medical Association (JAMA)*, December 11, 1981 - Vol. 246, No. 23; 2669-2674, in an article entitled, "Robert M. Zollinger, M.D.: Ohio's Natural Hormone." The article details Zollinger's career and provides some fascinating insight into this notable surgeon's personality.

BOOK SHELF

Berthold Lowenfeld on Blindness and Blind People. *Published by the American Foundation for the Blind.*

Berthold Lowenfeld has been called, "the 20th century's most prolific, scholarly, informative, thoughtful and creative writer in education of the visually handicapped."

The writings selected for this volume, reflecting the author's diverse experience in the field of blindness, cover such topics as education, psychology, social issues, historical perspectives (including a remembrance of Helen Keller), and general issues such as "Non-Visual Art."

Copies of the book are available from the Publications and Information Services Department of the American Foundation for the Blind, 15 W. 16th St., N.Y., N.Y. 10011. The price of the book is \$8.

Horse Sense and Humor in Kentucky. *By Eshe Asbury; The Thoroughbred Press.*

Cincinnati surgeon, Eshe Asbury, M.D., has long been known for his way with horses. . . and even longer for his down home, gentle sense of humor. It seems only natural then that he should combine the two in book form — and so he has, in this slim volume packed full of tales that explore the traditions, ways and peculiarities of his native Kentucky, and the thoroughbreds he breeds there — as much a part of his life as the medicine he practices.

Little is left untouched by his wit, and he easily prods the humor out of the most unlikely subjects. Education, music, even religion, take their turns at the end of his pen — as, of course, does medicine.

Dr. Asbury is donating the proceeds from the sale of his book to Kentucky's Berea College — a fitting gesture from a Kentucky gentleman.

Copies of the book are available from the Thoroughbred Press of Lexington, Kentucky. Price information was unavailable.

"Market Days" are rapidly approaching

The day of the solo practitioner is on the way out, hastened by increasing competition and the skyrocketing cost of opening a practice.

"The cost of doing business is so astronomical the little guy has to merge," comments Irwin Braun in a recent issue of the *American Medical News*. Braun is president of a small midtown Manhattan advertising firm that bears his name.

"We're all up against it nowadays," he says. "Competition is growing in every field. Physicians can't afford to sit back and wait for patients. They're going to have to develop a media strategy and market their services."

Braun's figures show 14,000 new physicians entering practice each year, and it is among the younger professionals, he says, that the acceptance of advertising is greatest.

The Future of the Academic Health Science Centers

(continued from page 171)

exist at opposite ends of a medical care continuum and require the institution to have multiple and complex simultaneous medical care objectives in order to carry out the missions of society and of the colleges.

Planning and regulatory influences are likely to encourage ambulatory care delivered through better organized sites and programs, for example, health maintenance organizations or model practices. Students will spend more time in model sites and there will be continuing societal pressures for more professionals to choose careers in ambulatory care.

Most academic health science centers also will be encouraged by factors both inside and outside the center to establish more and better tertiary care programs. The combination of their facilities, their educational programs and their research make them ideal for this purpose. They frequently will become regional centers to which patients will come to receive the most complex, scientific, technical services. The federal and state governments and the regional and state health planning agencies will foster and support these developments.

THE FINANCE OF ACADEMIC HEALTH SCIENCE CENTERS

The prospects are complex and not optimistic for many of the traditional sources of financial support for the academic health science centers. Educational support, whether individual or institutional, is likely to

decrease. Research support will at best be constant, but is more likely to decline. Patient service reimbursement will be under greater pressures with diminished support for the care of the poor and the near poor, and a lesser percent of full reimbursement of cost for the hospital.

There are only two relatively more optimistic sources for increased funding. One is the reimbursement for professional service rendered, whether by fee-for-service or by contract. The other is local giving, deriving out of increasing local social responsibility, especially if taxes are reduced. Medical colleges and centers must gear up for tapping these sources to a maximum degree. Emphasis on documentation, billing and collecting systems is very important. Improved organizations and systems for fund raising also will be essential.

SUMMARY

What are the prospects for the 1980s? The public support for medical education is likely to be sharply reduced and research funding is likely to be constant at best. With the pressures of inflation and the problem in our economy, these are likely to be difficult financial times.

These institutions are necessary for society to function. If we did not have them, we would invent them. Although there may be many difficulties ahead, we may be optimistic about our capacities to respond to them and to manage them, to move ahead, and to accomplish the work that we wish to do. **OSMA**

Robert S. Daniels, Cincinnati, is the Dean of the College of Medicine, University of Cincinnati Medical Center



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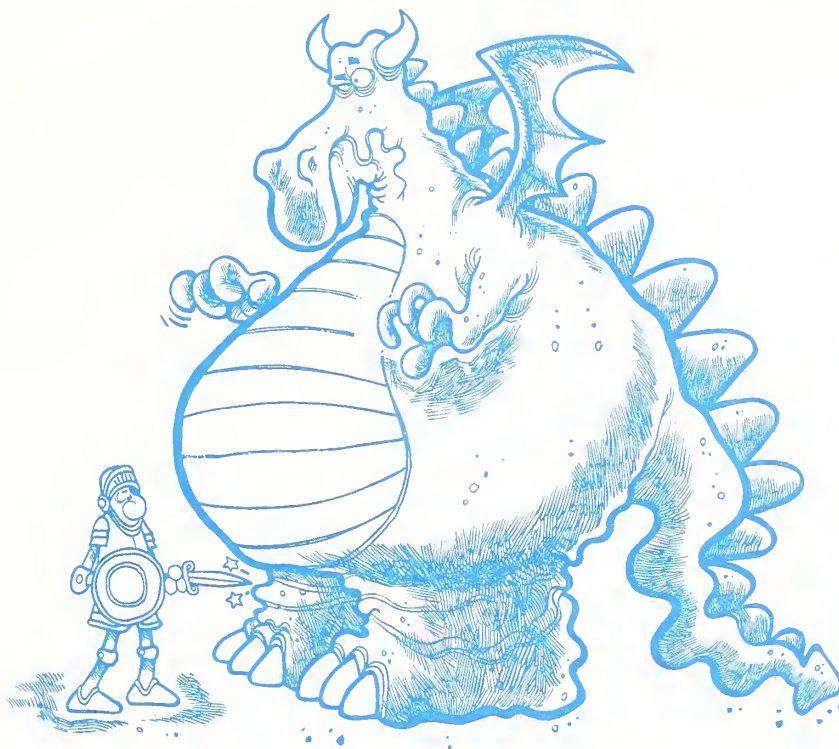
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MALPRACTICE

How Ohio physicians are taming the dragon

By Rebecca J. Doll

The news was grim. "New York MDs debate liability issues," reads one headline. "High medical liability insurance premiums could create a situation in which New Yorkers would find themselves cut off from a full range of medical services Americans now take for granted," states another. Physicians, the accompanying article says, may be unable to provide necessary care due to their inability to purchase liability insurance at a reasonable rate.

Although the article could have been published in 1976, during what has become known as the "malpractice insurance crisis," it was actually published on October 30, 1981. To

many insurance professionals, the New York situation may be a harbinger of things to come.

At the peak of the 1976 crisis, physicians found themselves unable to purchase insurance at any price. Heavy losses coupled with inadequate premium rates drove many of the large insurance companies out of the professional liability market. Faced with the possibility of being unable to care for their patients, physicians throughout the country turned to their state medical associations for help. The solution for many, including the OSMA, was to form their own professional liability insurance companies.

Today, OSMA's company, Physicians Insurance Company of Ohio (PICO), is one of the largest and most successful of the physician-owned insurance companies.

In addition to professional liability insurance, PICO now offers life insurance, homeowners, automobile and other property and casualty coverages to OSMA members. A subsidiary company, Professionals Insurance Company (PIC) offers liability and other types of insurance to ancillary medical professionals such as nurses, dentists and laboratory technicians.

Yet liability insurance for members of the OSMA remains the top priority

for PICO. Its Board of Directors have taken some carefully controlled steps to insure that liability insurance will be available should a crisis occur in the future. That future may already be upon us, warns PICO Board Chairman William H. Wells, M.D., Newark. Insurance professionals are predicting that a new crisis will begin to unfold in the next twelve months and peak about 1983.

What steps has PICO taken to insure the availability of professional liability insurance in the coming crisis? According to PICO President, Joseph Gilmore, the first and most important step PICO has taken is to adequately capitalize the company and to charge adequate premium rates from the very beginning.

"For companies which are undercapitalized and which charge inadequate premium rates in today's highly inflationary economy, the time of reckoning is inevitable," says Gilmore. "The medical associations in those states where this condition exists will experience problems that will dwarf the problems of the 1975 crisis."

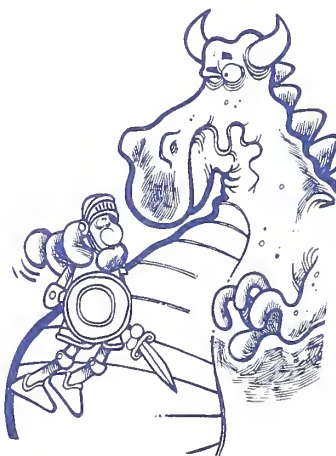
The number of claims per 100 doctors has shown little fluctuation since 1975. What has gone up a lot and continues to increase is the average settlement per claim.

"This is due primarily to inflation," says Gilmore. "If prices for coverage do not rise to appropriate levels, if we assume that inflation will remain unchecked and if no one finds a way to diminish the claims incurred per 100 doctors, at some point in the future, doctors will once again be unable to buy insurance, only this time it will be due to price rather than unavailability."

The only way to insure that this does not happen is to adequately capitalize and to charge appropriate rates. If the companies have not done this, they will have but two choices, Gilmore says.

"Within these companies, the only choices are insolvency or to raise rates dramatically to not only cover the present and future, but also to catch up for the years when rates were inadequately low. Those are two very

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tough choices."

New York is a good example. Last year they were faced with a 71% rate increase. Most experts agree that the rates charged were not adequate in the first place nor was the company itself adequately capitalized. Now the company has a serious problem. Not only must it set rates more adequately now and in the future, it must also play catch-up and this aggravates the situation almost to the point of no return. The New York doctors are now faced with deciding not only how they're going to continue to practice medicine but how much of the increase they'll have to pass along to their patients.

Fear of this type of situation is what prompted PICO officers to set realistic capitalization goals and premium rates from the beginning.

"During 1977 and 1978, PICO's rates were higher than most other companies," Gilmore notes. "At that time, we explained to our policyholders that if we erred in setting rates, we'd err on the side of conservatism. We have taken the most conservative position possible and it has been deliberate. We guaranteed our policyholders that if rates proved to be excessive, the money would be returned to them in the form of policyholder or stockholder dividends or be added to the surpluses of the company which only makes their company stronger and thus more able to adequately protect them in times of crisis."

According to Gilmore, PICO has to date shown a very modest underwriting profit. Taxes have remained appropriately low and PICO has managed to retain a great deal of money in its reserves, which today total over \$60 million.

A second step PICO has taken is to deeply involve physicians in the claims process. Dr. Wells explains that when PICO gets a case, it is thoroughly studied by the Claims Department and it assigns a certain amount of dollars it believes the case will cost. Then the claims committee, comprised totally of doctors, determines what it believes a claim will cost. If during the course of

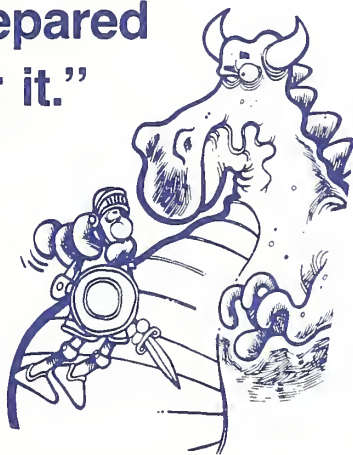
resolving that claim, the committee feels it is going to cost more, it will adjust the reserves to reflect this.

"Involving physicians in the process gives us added strength that the other companies don't have," Dr. Wells says, adding that "These physicians bring to the process an expertise that cannot be overevaluated."

In addition to adequate capitalization, realistic premium rates, and significant physician involvement, PICO strives to find ways to reduce the incidence of malpractice in Ohio, and thereby hold premium increases to a minimum. One important way PICO accomplishes this goal is through what is known as a Risk Management Committee.

"We know that inflation, if it continues unchecked, will cause rates to rise," Gilmore says. There is very little we can do about inflation, so what we must do is find a way to reduce the number of claims per 100

"When the crisis hits, as it will . . . we'll be prepared for it."

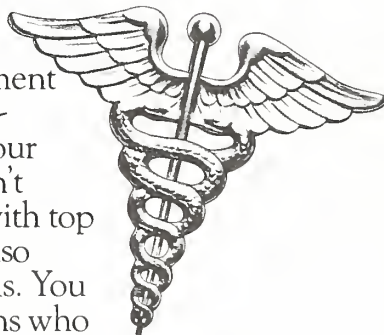


doctors. The Risk Management Committee carefully studies all claims that are received and categorizes them. We know for example, how many losses doctors in a specific risk classification have incurred. We know from what part of the state the losses have come, we know what they did wrong if anything, we know what the cause of the loss was, we attempt to determine how it could have been prevented and what should or shouldn't have been done that may have prevented the loss."

"When the crisis hits again, and I believe it will, I'm confident we'll be prepared for it," assures Dr. Wells. "We know what has to be done to protect Ohio doctors and we're doing it. OSMA members can be proud of their determination and foresight in protecting their ability to practice medicine in the future." **OSMA**
Rebecca J. Doll is OSMA's Director of Communications

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*Hannemann, R. E., Erb, R. J., Stoltman, W. P., Bronson, E. C., Williams, E. J., Long, R. A., Hull, J. H. and Starbuck, R. R.: Digital Plethysmography For Assessing Erythrityl Tetranitrate Bioavailability. Clin Pharmacol and Ther 29:35-39, 1981.

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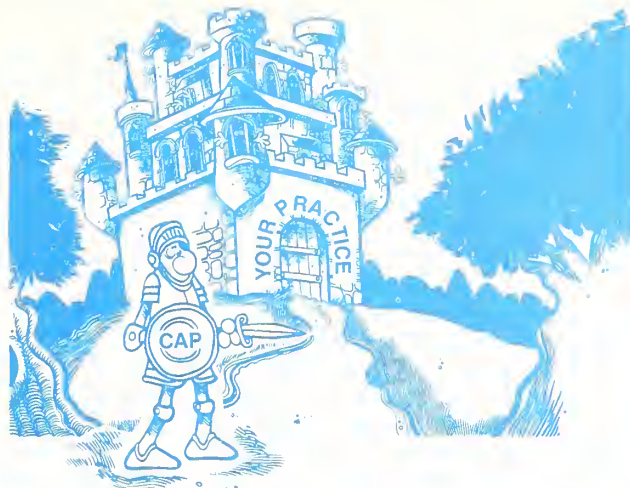
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Career Protection

PICO's latest policy protects your
practice . . . retroactively

By Linda P. Trafford

Having just celebrated its fifth birthday last fall, PICO, Physicians Insurance Company of Ohio, the professional liability insurance company started during the malpractice "crisis" by the OSMA and Ohio doctors, is beginning to experience the joys of maturity. No longer a newborn insurance company in a field that is uncertain at best, now more than ever before PICO is being creative in its approach to protecting the interests — financially and professionally — of Ohio's doctors.

From its inception, PICO has been considered an innovator among the physician-owned companies. Its new Career Assets Protection policy, "CAP," is one more example of PICO's creativity in designing insurance products that solve some of the profession's unique problems. "CAP" is a program of retroactive professional liability coverage, and is to date the only coverage of its kind in the nation. The "CAP" policy covers the physician from the date the policy is issued **backwards** to the beginning of his/her practice. It can add a layer of protection to that which may already exist, or if the physician was at one time "bare," this policy can in certain instances become the primary

coverage. PICO will issue "CAP" coverage to a physician no matter who his professional liability carrier has been in the past.

As an example of how "CAP" works, suppose a physician is an OB/GYN who has been in practice for 20 years. Until ten years ago, he only carried primary limits of \$25,000/\$75,000. In today's economic environment, however, with increasingly frequent claims and large monetary awards common, he is now

which this new coverage addresses. If a suit were to be brought today for a medical incident in 1970, the coverage limits which would apply would be those of the policy he carried then. The amount of any jury award or out-of-court settlement in excess of \$25,000 would therefore have to come out of his pocket. As most doctors realize, awards over this amount in today's litigious liability climate are very common.

The unique feature of the "CAP" coverage is its application in so many professional situations. A physician who has just completed a residency and is unsure about the coverage that had been carried by the employer hospital can reduce the uncertainty by the purchase of one "CAP" policy. Likewise, a retiring doctor can purchase a "CAP" and leave his practice with a feeling of security, knowing the "loose ends" have been tied up.

The coverage is available in increments of \$1 million/\$1 million, up to \$5 million/\$5 million, so that the total limits available to the physician for past years increase by that amount. The PICO "CAP" becomes excess coverage over any applicable primary policy in effect at the time of the

The unique feature of the CAP coverage is its application in so many professional situations.

concerned about suits involving children born during the early years of his practice. Because the statute of limitations applies for a longer period of time in the case of an alleged mishap involving a child, the physician has legitimate concerns,

incident in question.

While PICO Board members and management have been conducting educational programs for Ohio physician groups for several years, last May marked the beginning of an exciting new phase of presentations aimed at informing doctors about the medical professional liability climate. PICO's first "Loss Awareness" program, based on its claims experience since the inception of the company, received an enthusiastic reception at the OSMA Annual Meeting in May, 1981, in Cleveland. The program, approved for Category 1 CME credit, involves a combination of slides and discussion of the company's medical professional liability claims data since January, 1977.

The presentation was developed by the Risk Management Committee of PICO, whose members are William M. Wells, M.D., chairman; Thomas W. Morgan, M.D.; James L. Henry, M.D.; and A. Burton Payne, M.D., all of whom are PICO Board members. A

Many interesting questions have been precipitated by the detailed review of PICO's most costly claims.

slightly condensed version of the program was presented to thirty Ohio physician groups (medical society, specialty society, and hospital staff meetings) during the fall and winter of 1981-82, and is being scheduled for additional presentations this spring.

Physicians' reactions to this claims information have been very positive. Many interesting questions have been precipitated by the detailed review of PICO's most costly claims, as well as which specialties account for them. The data used for this presentation will be updated at least semiannually.

For the past three years, PICO has also been conducting educational seminars for residents about medical professional liability insurance. The program for these groups covers the distinction between occurrence and claims-made coverages; an explanation of typical limits and risk classifications;

and a review of the current claims situation in this insurance line. Approximately forty such programs have been conducted for groups ranging in size from five people to one hundred. These programs have received much praise from both residency program directors and residents themselves as being very helpful to these young physicians just entering practice.

PICO's "Young Physicians" program of discounted medical professional liability insurance for residents and first- and second-year new practitioners is already two years old. For residents, "moonlighting" coverage is available at 75% off the premium for the company's lowest risk classification. Primary limits available are \$100,000/\$300,000 and \$200,000/\$600,000 on an occurrence basis.

New-in-practice doctors are eligible for premiums at a 65% discount their first year in practice. Second-year doctors can receive coverage at a 30% discount. The limits available under this plan are the primary limits mentioned above, plus \$1 million/\$1 million excess (written over \$200,000/\$600,000). Not until the physician's third year of practice does the full regular premium charge apply.

This program was developed to aid new doctors during their first practice years, when expenses are highest. The discounted coverages give these practitioners a chance to get firmly established before they are required to assume the full premium obligation.

PICO's plans for the future include a continuation of the current educational programs, as well as the "Loss Awareness" presentations, with frequent updates in the data presented. The "Young Physician" professional liability plan has already become a permanent fixture in PICO's attractive assortment of coverages for doctors. And the "CAP" policy promises to become one of the most innovative, useful coverages doctors have been offered in many years. With its record of financial growth, policyholder and shareholder support, and creative concepts in insurance coverage, PICO seems well on its way to becoming the leader in medical professional liability insurance in the Midwest. **OSMA**

Linda P. Trafford is Director of Communications, PICO

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profiles

Dr. John Judge and the Shroud of Turin

By Gina DiBlasio Cummins

A continent away in a guarded chapel in Turin, Italy, lies a wooden casket within an iron chest. Bundled in asbestos, it is kept under several locks each of which has a different key. Inside lies what appears to be a precious testimony to the past; to Christianity; and perhaps, a miracle in and of itself.

Rolled around a velvet staff within the casket is a yellowed piece of linen

claimed to be approximately 2,000 years old. Medical and scientific researchers theorize that the cloth is scorched by a shadowy imprint of a human double image — an image, many feel, accurately matches the Bible's description of the crucified Christ lying in his tomb.

That this Shroud may be the burial cloth of Jesus Christ is a question which has intrigued man since at least

the 14th century. And considering that Christianity is based on the resurrection, the Shroud, if authentic, presents overwhelming implications.

The search for authenticity has resulted in medicine, particularly pathology and forensics, playing a significant and even leading role in the scientific analysis of the Shroud. In fact, a number of physicians have made researching the Shroud a virtual



The image of a man's face, although not easily captured on film, has left an unmistakable impression on the Shroud itself.

avocation.

One such physician is John R. Judge, M.D., a Cleveland pathologist who became fascinated with the Shroud 12 years ago when he was given a book on the subject. "From that moment on, I've read everything about the Shroud I could possibly get my hands on," he says.

Although he has never personally viewed the Shroud, he has spent an enormous amount of time doing research and has given lectures and slide presentations to interested church and hospital groups. "It's normally difficult to keep an interest this long unless it really piques your fancy," observes Dr. Judge, "but the research is ongoing and I'm always tickled to read new things."

The figure on the cloth . . . appears to be a male figure, approximately 5 feet, 10 inches in repose, and around 170 to 180 pounds.

Dr. Judge feels that his fascination with the Shroud is not necessarily based on his religious upbringing. "Although I was raised a strict Catholic, when I learned of Christ's suffering, it really didn't mean much. But after reading so much about the Shroud and after talking with individuals who have seen it, I can fully appreciate how much this individual suffered. I think I'm also drawn to the Shroud because as a youngster, I regarded the church as the rock. But like everything else, the church has changed over the years. Here is one thing — the Shroud — which seems immune to change."

Dr. Judge says that medicine, science and history have been quite successful at piecing together the Shroud's puzzling past. The figure on the cloth can be compared to a photographic negative and appears to be a male figure approximately 5 feet 10 inches in repose, and around 170 to 180 pounds. The body is muscular, well-developed and fairly large for the time with a long, angular face, aquiline nose and beard.

Dr. Judge notes that after seeing this image, the first question that comes to mind is how did the figure appear on the cloth in the first place? "There is no doubt that the image scorched the cloth but did not penetrate the linen," he says, adding, "The closest theory we have was postulated by a physician from the Air Force Academy who feels that a sudden burst of radiant energy was transferred from the body to the cloth, causing the image to scorch the linen." To date, there are no other plausible theories to explain this apparent transformation.

Dr. Judge cites other reasons for his interest in the Shroud: (1) the figure on the Shroud seems to match the Biblical descriptions of the crucifixion, and (2) modern technology has been

unable to refute the Shroud's authenticity; on the contrary it thus far corroborates religious claims of authenticity.

He notes that the more you delve into the subject medically, scientifically and historically, the more it coincides with what has been written in the Bible. Some examples which Dr. Judge cites are as follows:

- The Gospel says that Jesus was scourged:

Dr. Judge notes that there is evidence that the figure on the Shroud was severely beaten. "In fact, the Shroud shows around 120 lash marks all over the body. From the various angles of the lash marks, forensics can tell that the beatings were administered by two individuals of different heights on each side of the body."

He says that the scourging was most likely done with an ancient Roman weapon called a Flagrum. "This weapon had three whip-like extensions with small lead balls attached to tear flesh." Dr. Judge notes that the lashes on the Shroud occur in threes —

matching the Flagrum's description.

- The Bible says that Jesus was struck in the face:

"The face on the Shroud shows a marked puffiness under the right eye as well as other facial wounds," says Dr. Judge, adding, "and the bridge of the nose looks distended as if it could be broken."

- The Bible tells of Christ being forced to carry his own cross:

Dr. Judge explains that the shoulder wounds on the Shroud indicate a severe smudging — as if the blood from the lash marks were chafed by a heavy object such as the cross.

- Jesus had help carrying the cross since he fell repeatedly:

The knees on the Shroud are severely damaged as if the figure had frequently fallen.

- Christ wore a crown of thorns:

"There is a strange haziness which appears on the back of the figure's head, indicating that instead of a crown of thorns, Jesus may have worn a cap of thorns," says Dr. Judge. He notes that the blood stains extend from the forehead down to the back of the head as if a cap of thorns was forced down on the entire area.

- Jesus was nailed at the hands and feet:

Dr. Judge points out that the typical artist's rendition of the crucifixion scene is in error. "There is no way a 180-pound body could remain suspended for long if nailed through the palms," says Dr. Judge. He explains that the Shroud clearly shows blood flow patterns from the wrists and the feet. Nails through the wrists could support a crucifixion victim of this size.

- Christ's legs were not broken, but a spear was thrust in his side to check if he was dead:

Dr. Judge says that the Shroud shows no evidence of broken legs — but a large wound exists in the right side of the body.

Aside from these medical and scientific findings which Dr. Judge feels fit the Bible's descriptions like a glove, there is further information which supports the Shroud's authenticity.

"Physicists claim that the stains on

the Shroud are blood, but not enough of a sampling has been available to determine whether or not it is human blood. The complete absence of pattern strokes indicates that the blood stains were not painted on by a forger," says Dr. Judge. He notes that forensic study has shown that the blood flow patterns are real since the liquid and solid content of blood make certain patterns which are authenticated on the Shroud. The blood flow patterns are vertical, typical of a crucifixion victim. "In striving to get air into the lungs, the victim painfully raised himself, then quickly collapsed, causing the bleeding wounds to shift pattern flow." He notes that a forger in ancient times would have had to understand modern day forensics to be able to forge such an accurate display of blood flow patterns. In addition, the figure on the Shroud has an abdominal protuberance which is characteristic of crucifixion victims who typically suffocate to death.

Another noteworthy feature is an elongated, hazy area down the back of the figure. In ancient times, Jewish men wore their hair in an oiled pigtail during the Holy Days. Since the Sabbath was approaching, this hazy area may be the pigtail which indicates this figure is Jewish.

Dr. Judge points out that Orthodox Jews always washed and anointed a body before burying it. "But the body on the Shroud has clearly not been cleansed. The Sabbath was so close at hand and they may not have had time to clean the body before burial. It was probably more important to bury the body before sundown with the intention of returning to properly prepare it," says Dr. Judge.

Virtually all the researchers have attempted to ascertain the age of the Shroud. This is especially true since the Shroud only definitely surfaced in the 1300s in Liery, France. A Belgian botanist found dust particles on the Shroud which he identified as fungal and weed spores indigenous to the area of the Holy Land. This is evidence, according to Dr. Judge, "that the Shroud must have been in the Holy Land sometime before it was

brought to France."

This still does not help to establish the Shroud's age, but during the last exposition of the Shroud, fascinating evidence of its age surfaced. A forensic pathologist found that there were coins on the figure's eyes. A common practice in ancient Jerusalem was to place coins on the lids of the dead to keep them from opening. Upon examination, the coins were found to match those issued during the Pontius Pilate era.

Dr. Judge says that one of the most recent attempts to accurately date the cloth was canceled this past year due to tragic circumstances. On the day the Pope was shot, a delegation was in Rome to petition for permission to take eight strands of the cloth in order to conduct a modern-day carbon-dating test. Dr. Judge feels that permission would have been granted to conduct this test had the misfortune not occurred. "The Church is just as anxious, if not more so, to authenticate the Shroud," he says.

"Because of the Church's concern to protect what may be an authentic relic, the Shroud has remained in Turin since 1578 — where it's being rather jealously guarded," says Dr. Judge. "Which is one reason why it is seldom exhibited." However, he feels that the Church's position is valid for several reasons. "First, the possibility of the Shroud's authenticity makes it priceless, and second, in this modern era, it is necessary to keep what may be an authentic relic behind bulletproof glass and other safety devices for protection. Unfortunately, we're never sure when a deranged attacker may try to destroy the Shroud, as one individual did to the Pieta."

He notes that although the cloth is relatively intact after 2,000 years of known existence, it is a very delicate object and must be handled accordingly.

In spite of the information learned thus far and despite continued research to authenticate the Shroud, no one will ever be 100 percent sure whether the Shroud of Turin is truly Christ's burial cloth.

Nonetheless, the continued scientific

search for authenticity will likely continue to be at the very least, an incredible historical search — conducted in large part by men and women of medicine. **OSMA**

Gina DiBlasio Cummins is Assistant Editor of Synergy and staff writer for the Journal.

"Medicine, science and history have been quite successful piecing together the Shroud's puzzling past."



Dr. John Judge discusses some of the medical facts revealed by studies of the Shroud.

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References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease*, op. cit., p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, op. cit., pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med* 89 (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.

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OSMA 1982 ANNUAL MEETING

EXPANDING HORIZONS

THE WRIGHT WAY IN '82

The 1982 Annual Meeting takes on a new look this year. The House of Delegates will convene on Friday evening, April 30, for the first session of the House of Delegates, followed by Reference Committee Hearings on Saturday, May 1, and the final session of the House on Sunday, May 2.

This will be a convenience for those interested only in the House of Delegates.

Many scientific sections and specialty groups will be meeting during the Annual Meeting, which is scheduled through Wednesday, May 5. Please check the format listed below, in order to make your plans.

An event to keep in mind is the excellent performance of the Montgomery County Medical Society Glee Club, to take place on Friday evening, April 30, in the auditorium at the Dayton Convention Center,

immediately following the House of Delegates. After this event, a reception will be held in the Van Cleve Ballroom of Stouffer's, hosted by the Montgomery County Medical Society and its sister societies of the second district. Everyone in attendance is invited.

The traditional OMPAC luncheon will take place on Saturday, May 1, starting with a reception time at 11:30 a.m., followed by a luncheon and guest speaker, Mark Shields. Who is Mark Shields? He is an extraordinarily bright and humorous speaker with unmatched credentials as an analyst of the American political system. Mark is a well-known editorial page writer for the *Washington Post*, and syndicated columnist. He will discuss the latest developments under the Reagan administration and the mood of Washington. Mr. Shields has taught at

at Harvard and Wharton School of Business and served as analyst on the presidential elections on NBC and CBS.

The OSMA Auxiliary will be meeting at the Daytonian, April 30 through May 2.

The Auxiliary will be hosting an exciting and stimulating program. Be certain to check their events. An International Buffet and Fun Fest will be featured on Saturday, May 1, at 7:30 p.m. in the Daytonian Ballroom and OSMA members and spouses are invited.

A preliminary program, with details on events, will be mailed to the entire OSMA membership one month prior to the Annual Meeting.

Mark your calendar NOW!
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April 30 — May 5, 1982, DAYTON

Headquarters Hotel — Stouffer's Dayton Plaza Hotel, 5th & Jefferson Streets
Coheadquarters Hotel — Sheraton Dayton Downtown, 21 S. Jefferson Street
Auxiliary to OSMA Headquarters Hotel — Daytonian, Ludlow at Third Street
Resource Center — Dayton Convention Center, 22 Dave Hall Plaza
Art and Photographic Exhibit — Stouffer's Dayton Plaza Hotel

ST — Stouffer's
CC — Convention Center
SH — Sheraton

Friday, April 30

Pediatrics
Meeting — Van Cleve IV, ST

Emergency Resolution Committee
Luncheon/Meeting — Plaza XIV, ST

OSMA Delegation to AMA
Meeting — Van Cleve III, ST

District Caucus

9 AM - 12 NOON

12 NOON

2 - 4 PM

4 - 5:30 PM

Meetings

District 1, Room 302, CC
District 2, Room 203, CC
District 3, Room 306, CC
District 4, Room 204, CC
District 5, Room 303, CC
District 6, Room 207, CC
District 7, Room 307, CC
District 8, Room 308, CC
District 9, Room 309, CC
District 10, Room 202, CC

(continued on page 223)



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Resolutions Affecting OSMA Constitution and Bylaws

Introduced by:

The OSMA Council

Subject:

Medical Specialty Society
Representation

Whereas, Problems facing medicine are often focused initially on isolated medical specialties, but in reality affect all of medicine; and Whereas, Lines of communication and interaction between OSMA and specialty groups need to be fostered in both directions for the common good and coordination of efforts; and

Whereas, This communication should involve the most knowledgeable official spokespersons of specialty groups; and

Whereas, The AMA has already seated as voting delegates representatives of all major specialties; therefore be it **RESOLVED**, That the Bylaws of the Ohio State Medical Association be amended to provide for Medical Specialty representation in the House of Delegates as follows: Chapter 4. The House of Delegates Section 3. Representation of Medical Specialties:

A Medical Specialty, defined as a member organization of the American Board of Medical Specialties as listed in the current edition of Directory of Medical Specialties, is eligible to apply for representation in the House of Delegates.

To be eligible, the specialty society initially must have 50% of its physicians as members of the OSMA; at the end of its third year of representation, 75% OSMA membership has to be achieved. If

for 3 consecutive years thereafter this percentage is not maintained, then delegate status is subject to removal.

A Medical Specialty seeking representation shall apply to the Council. The Council shall consider applications and then recommend to the House of Delegates whether the applicant specialty qualifies for representation.

Each recognized Medical Specialty shall have one delegate and alternate who must be members of the Ohio State Medical Association. Each specialty will certify to the Association at least 60 days prior to the Annual Meeting both the names of its delegate and alternate, and its membership certification as required by subsection (b) above. A Medical Specialty delegate shall have all rights, privileges and duties as other delegates. The delegate will be seated in the House of Delegates with the councilor district in which his/her county medical society is represented. Failure to comply with Section 3, Chapter 4, shall result in loss of representation. That determination shall be made by the Council, with appeal provided to the House of Delegates; and be it further **RESOLVED**, That the remaining sections of Chapter 4 be renumbered accordingly beginning with Quorum as Section 4; and be it further **RESOLVED**, That in case of conflict as to which state organization most completely represents a recognized specialty, the final decision rests with the House of Delegates of the Ohio State Medical Association.

Introduced by:

Sixth District Delegation

Subject:

Parliamentarian

Whereas, The business of the House of Delegates of the Ohio State Medical Association should proceed with dispatch and proper order without parliamentary mistakes; therefore be it **RESOLVED**, That the Ohio State Medical Association provide an accomplished and competent parliamentarian who is well versed in Sturgis Rules of Parliamentary Procedure to insure orderly procedure for each session of the House of Delegates.

Introduced by:

The OSMA Council

Subject:

Annual Meeting Format

Whereas, The Resolution No. 12-81 states that "RESOLVED, That the Annual Meeting of the House of Delegates of the Ohio State Medical Association be scheduled as soon as practical, as follows: "The opening session of the House of Delegates will begin on Thursday A.M. and the closing session of the House of Delegates will begin by noon on Saturday."; and Whereas, The 1982 House of Delegates format is modified to Friday, Saturday and Sunday, because facilities were not available to comply with Resolution No. 12-81; and Whereas, The OSMA Council, after

Continued on page 225

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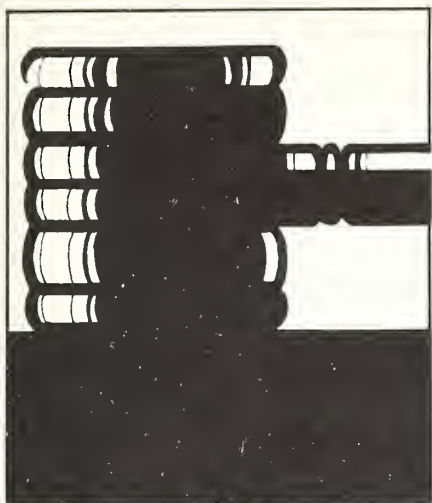


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council proceedings

PROCEEDINGS OF THE COUNCIL

January 30, 1982

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, January 30, 1982, at the OSMA Headquarters, 600 South High Street, Columbus, Ohio.

Those present were: Stewart B. Dunsker, M.D., Cincinnati; C. Douglass Ford, M.D., Toledo; Robert G. Thomas, M.D., Elyria; David A. Barr, M.D., Lima; John E. Albers, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; Alford C. Diller, M.D., Van Wert; Benjamin H. Reed, M.D., Wauseon; Edward G. Kilroy, M.D., Cleveland; Joseph P. Yut, M.D., Canton; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; A. Burton Payne, M.D., Ironton; D. James Hickson, M.D., Mt. Gilead; S. Baird Pfahl, Jr., M.D., Sandusky; Joseph L. Kloss, M.D., Akron; John H. Ackerman, M.D., Director, ODH, Columbus; James E. Pohlman, Esq., Columbus; Joseph K. Gilmore, President, PICO, Pickerington; Sylvan L. Weinberg, M.D., Dayton; and Shirley C. Davies, President, OSMA Auxiliary.

Those present from the OSMA Staff were: Hart F. Page; Herbert E. Gillen; Jerry J. Campbell; Robert D. Clinger; Katherine E. Wisse; Rebecca J. Doll; Robert E. Holcomb; Gail E. Dodson; David C. Torrens; David W.

Pennington; Eric Burkland; Michael L. Bateson; Louis N. Saslaw; Catherine M. Costello; and William E. Fry.

Announcements by President Dunsker

The Council was called to order by President Dunsker who distributed a letter from Summit County Medical Society, and a memo dated January 4, 1982 on Leadership Conference assignments involving Dr. Abromowitz, Mr. Pennington, Dr. Diller and Dr. Lewis.

Dr. Abromowitz reported on ideas to increase responsiveness from members and communications with them.

Dr. Diller discussed proposed solutions for addressing cost shifting in Welfare and other programs.

A letter from Dr. Evelyn L. Cover, President of the Ohio State Medical Board, concerning amphetamine legislation, was referred to the Chairman of the Legislative Committee.

Administration

The minutes of the December 12, 1982 meeting of the Council were approved.

Mr. Page reported on the January 11-12, 1982 Conference of the Canadian Medical Association Executives, where he was an invited speaker on medical society management education programs.

He announced the appointment of David C. Torrens as Administrative Services Manager. He retains his duties as Associate Director, Dept. of Education & Meeting Management.

The Council received a letter from T.L. Johnson, M.D., President of the Van Wert County Medical Society announcing that the society is nominating Alford C. Diller, M.D., as a candidate for President-Elect of the Ohio State Medical Association.

A letter from Dr. Evelyn L. Cover, President of the Ohio State Medical Board, regarding physician testimony, was referred to the Medical Services Review Committee.

Medical Student Liaison Committee

Dr. Thomas and Mr. Saslaw reported on the January 20, 1982 meeting of the Medical Student

Liaison Committee. The following recommendations were adopted:

- 1) That an ad hoc committee composed predominantly of students be appointed to study the student financial aid situation in Ohio and make suggestions to Council for possible actions.
- 2) That the OSMA compile a list of physicians who may be willing to offer preceptorships for students between their first and second year of medical school. This list would include specialty, location, and other pertinent details. The list or portions of it would be made available to students or medical schools on request.
- 3) That the Council instruct OSMA staff to contact PICO to determine
 - 1) if an appropriate product exists for medical student liability, and
 - 2) if no product exists, determine whether it is practical to develop a suitable one.

The minutes were filed.

Financial and Membership Department

Committee on Auditing and Appropriations — The January 29, 1982 minutes of the Committee on Auditing and Appropriations were presented by Dr. Pfahl.

The officers were authorized by the Council to evaluate interest plans on a mortgage loan from the Employees Pension Trust and to select the appropriate mode of repayment.

Service Corporation Formed — The Council approved the capitalization of an OSMA-owned for profit service corporation.

The President nominated and the council approved the following directors for the company: Dr. Dunsker, Dr. Thomas, Dr. Castele, Dr. Abromowitz, Mr. Gillen, Mr. Pohlman, and Mr. Gilmore.

The motion to fund the corporation with \$300,000 was approved.

The Council authorized that a mechanism for distribution of the funds be determined by officers of OSMA in consultation with financial advisors.

The following recommendations of the Committee on Auditing and Appropriations **were approved**:

- 1) That \$40,000 of the unused 1981 budget balances be reserved for the purchase of the data processing equipment already approved.
 - 2) That the \$5 resident application processing fee be discontinued.
 - 3) That the OSMA pay for one pre-Annual Meeting District Caucus.
 - 4) That the OSMA Council not submit a Constitution and Bylaws amendment resolution for separate OSMA dues billing.
 - 5) That the OSMA officers, Dr. Kloss and Dr. Dorner, discuss the dues billing program with the Summit County Medical Society officers.
- The report was filed.

Treasurer's Report — Dr. Barr presented the report of the treasurer. The report was filed.

The membership statistics were accepted by the Council.

Department of Education & Meeting Management

Mrs. Dodson presented the report of the Department of Education and Meeting Management for information.

Department of Government Relations

Mr. Pennington presented a written report of the Department of Government Relations.

Committee to Study Voting Procedure in the House of Delegates — Dr. Reamy presented the January 29, 1982 minutes of the Ad Hoc Committee to Study Voting Procedures.

The Council **voted to approve** an automated system to facilitate the House of Delegates voting procedures at a cost not to exceed \$2,500. (Dr. Diller abstaining.)

Ohio Voluntary Effort — Dr. Abromowitz presented an update on the Ohio Voluntary Effort and distributed newly developed consumer awareness program materials to the Council.

Ad Hoc Committee on OSMA Committee Structure and Service —

The minutes of the January 20, 1982 meeting of the Ad Hoc Committee to Study OSMA Committee Structure and Service were presented by Mr. Gillen.

The Council **approved** the recommendations of the Committee on Structure and Service, and directed that a resolution incorporating these points be drafted and submitted at the Annual Meeting.

The recommendations are as follows:

- 1) That committee members be appointed for two-year terms;
- 2) That each committee member be limited to three consecutive two-year terms (as are the councilors);
- 3) That a member having served the maximum of three consecutive two-year terms is eligible for reappointment after not serving on the committee for a year;
- 4) That a member may serve on more than one committee;
- 5) That committee chairmen be appointed for one-year terms;
- 6) That committee chairmen are limited to two consecutive one-year appointments;
- 7) That committee chairmen who have served two one-year appointments as chairmen are eligible for reappointment as chairmen after having not served as chairmen for one-year;
- 8) That the one-year term as chairman may be in addition to the limit of three consecutive two-year terms;
- 9) That the above limits would apply to standing and special committees and would not apply to committees of the House nor ad hoc committees.

Department of Organizational Services

Task Force on Professional Liability — The minutes of the January 22, 1982 Conference Call of the OSMA Task Force on Professional Liability were received. Joseph K. Gilmore, President of Physicians Insurance Company of Ohio, addressed the Council.

He discussed proposed group medical professional liability coverage for members of the Ohio State Medical Association, the concept having been recommended by the Task Force.

The concept **was approved**.

Mr. Campbell presented the report of the Department of Organizational Services.

The report was filed.

American Medical Association

The Council **voted to endorse** Richard M. Steinhilber, M.D., Cleveland, for a position on the Residency Review Committee for the American Board of Psychiatry and Neurology.

Department of Health Education

Mr. Clinger presented the report of the Department of Health Education.

He discussed the January 27, 1982 meeting of the Ohio Block Grant Advisory Committee and stated that his written report will be mailed to the Council.

The report was filed.

Environmental Liaison Committee — Mr. Clinger presented the minutes of the January 13, 1982 meeting of the Environmental Liaison Committee.

The Council **approved** the Committee's recommendations as follows:

- 1) That a second mailing be sent to county medical society presidents urging formation and operation of environmental committees at the local/county level.
 - 2) That a conference on high-priority environmental issues, including toxic waste disposal, be held in conjunction with the 1983 OSMA Annual Meeting in Columbus.
- The report was filed.

Department of Federal & State Legislation

Committee on State Legislation — Dr. Payne presented the minutes of the January 20, 1982 meeting of the Committee on State Legislation.

The following positions **were adopted**:

H.B. 820; regarding coverage of certain services by Health Maintenance Organizations — **actively oppose**.

H.B. 713; to authorize diethylstilbestrol program — **no**
(continued on page 221)

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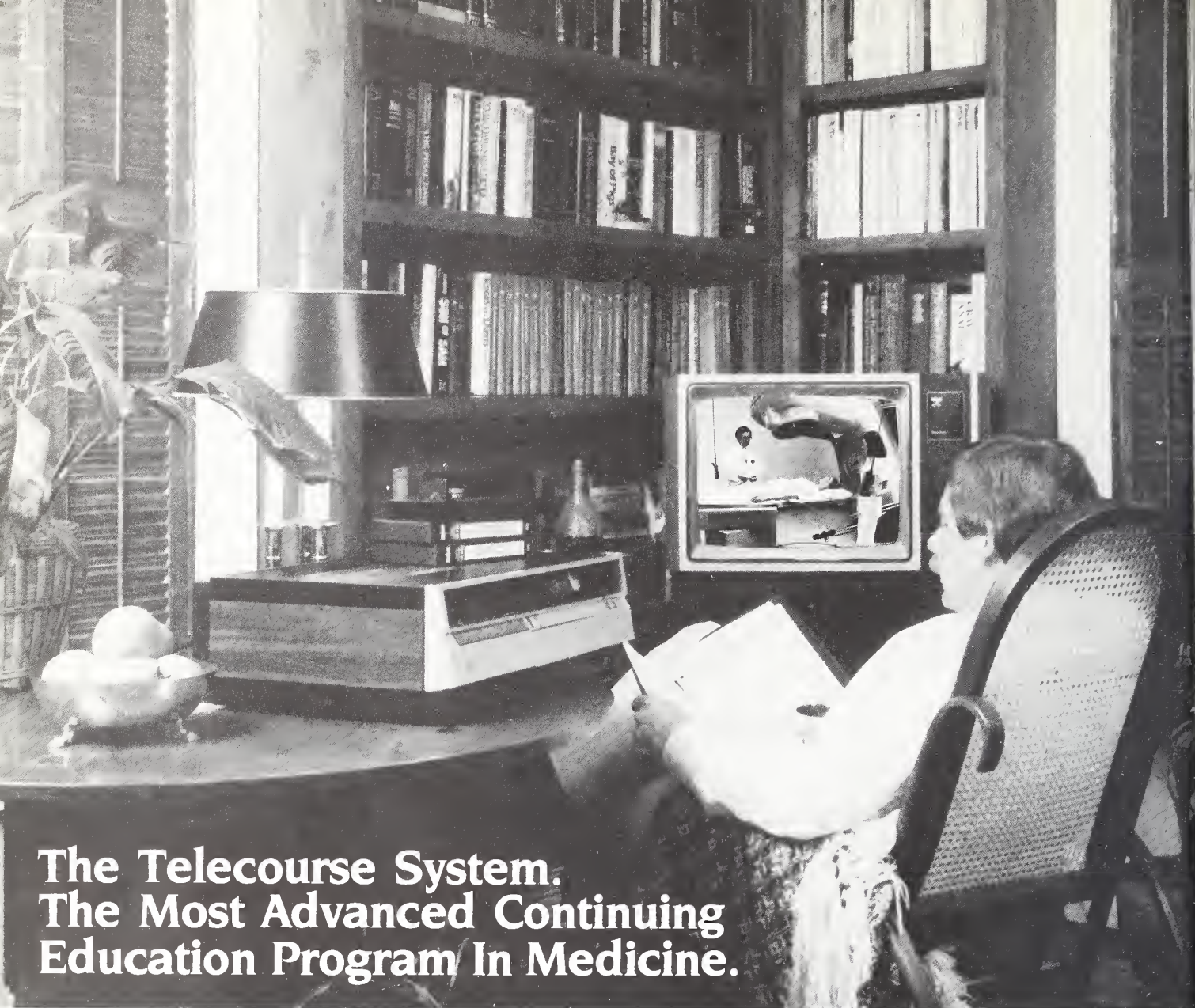
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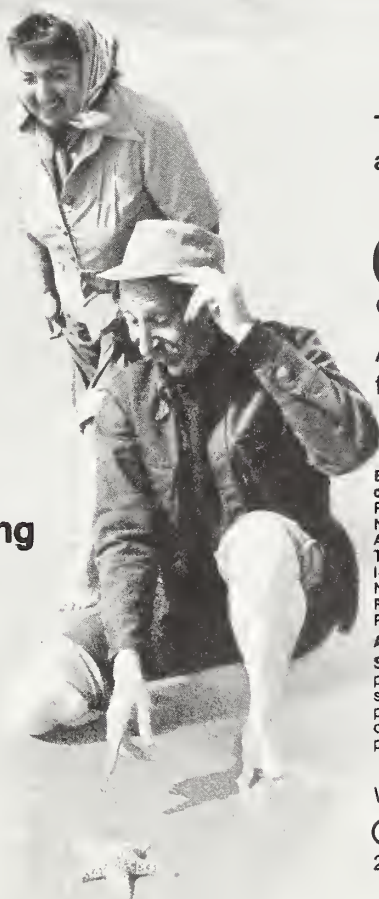
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January 6, 1982; member OSMa and
AMA.

JAMES F. MARTIN, M.D.,
Huntsville; University of Cincinnati
College of Medicine, 1941; age 64; died
January 7, 1982; member OSMa and
AMA.

ELEANOR J. RECTOR, M.D.,
Friday Harbor, Washington, 1936; age
73; died December 24, 1981; member
OSMa and AMA.

RODOLFO L. SINDIONG, M.D.,
Cincinnati; Manila Central University,
1955; age 53; died January 7, 1982;
member OSMa and AMA.

QUINTON B. SMITH, M.D., Tiffin;
Case Western Reserve University
School of Medicine, 1943; age 63; died
December 29, 1981; member OSMa
and AMA.

DONALD A. SNYDER, M.D.,
Cleveland; University of Cincinnati
College of Medicine, 1946; age 61; died
December 30, 1981; member OSMa
and AMA.

WALTER R. STAGER, M.D., Dover;
Creighton University School of
Medicine, Omaha, 1933; age 76; died
December 6, 1981; member OSMa and
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GEORGE STIMSON, M.D., Miami,
Florida; University of Michigan
Medical School, Ann Arbor, 1923; age
84; died December 16, 1981; member
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WILLIAM E. STORER, M.D.,
Middletown; George Washington
University School of Medicine, 1940;
age 66; died December 7, 1981;
member OSMa and AMA.

GUY H. WILLIAMS, M.D., Aurora,
Illinois; Case Western Reserve
University School of Medicine, 1932;
age 74; died January 7, 1982; member
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SYDNEY BLAUGRUND, M.D.,
Cleveland; Temple University School of
Medicine, 1921; age 84; died December
28, 1981; member OSMa and AMA.

MAXWELL BURNHAM, M.D.,
Painesville; Case Western Reserve
University School of Medicine, 1946;
age 61; died December 28, 1981;
member OSMa and AMA.

SOL ALLEN DANCHIK, M.D.,
Columbus; Ohio State University
College of Medicine, 1938; age 68; died
January 12, 1982; member OSMa and
AMA.

FORD E. EDDY, M.D., Marietta;
University of Cincinnati College of
Medicine, 1934; age 74; died December
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FREDERICK D. GOOD, M.D.,
Dayton; George Washington
University School of Medicine, 1948;
age 60; died May 18, 1981; member
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H. BRYAN HUTT, M.D., Buxton,
North Carolina; Medical University of
South Carolina College of Medicine,
1938; age 68; died December 15, 1981;
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HOWARD H. INGLING, M.D.,
Donnelsville; Case Western Reserve
University School of Medicine, 1935;
age 73; died December 15, 1981;
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Reynoldsburg; Havana Medical School,
Cuba, 1946; age 60; died December 28,
1981; member OSMa and AMA.

ALBERT KLEIN, M.D., Cleveland;
University of Padova, Italy, 1930; age
76; died January 1, 1982; member
OSMa and AMA.

Correction

Gwilym A. Edwards, M.D. and
Kenneth G. Hawver, M.D. were
erroneously listed as deceased in our
January issue. The Journal regrets the
error, and any confusion that may
have been caused.

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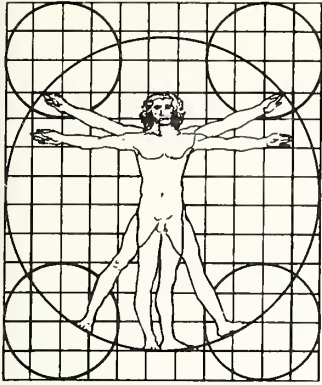
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TUBED ENTERAL NUTRITION AS PRACTICED IN A COMMUNITY HOSPITAL

C. A. Gerace, M.D.
R. E. Falcone, M.D.

Tubed enteral nutrition provides a viable alternative to the use of parenteral nutrition in selected patients. This article provides a step-by-step guide to enteral nutrition in the community hospital, its indications, technic of administration, and potential complications.

STUDIES HAVE SHOWN a surprisingly high incidence of malnutrition in our hospitalized populations.^{1,2} This data, coupled with an awakened interest in nutritional therapy, has led to a wealth of literature on parenteral nutritional therapy. Enteral therapy, which is relatively easy to supply and remarkably free of complications, has been somewhat overlooked in the literature.

Tubed enteral nutrition (TEN) is a form of enteral nutritional therapy that can be provided easily and safely in the community hospital. The basis of this form of alimentation is the infusion of nutrients directly into the intestinal tract via a tube, thus bypassing the oropharynx which for one reason or another is not functional. The following is a discussion of TEN as practiced at Riverside Methodist Hospital.

Nutritional Assessment

The first step to nutritionally repleting the malnourished patient is nutritional assessment. The combination of anthropometric, biochemical, and immunologic tests hereinafter discussed, provides a useful framework for initiating therapy, and judging nutritional status.

Anthropometric measurements. — The *triceps skin fold* measures the status of a patient's nonprotein calorie stores. This is measured by pinching a fold of skin away from the triceps muscle and measuring it with calipers (Fig. 1).

The *midarm muscle circumference* measures the somatic muscle compartment and is an indicator of the patient's protein



FIGURE 1: Triceps skin fold

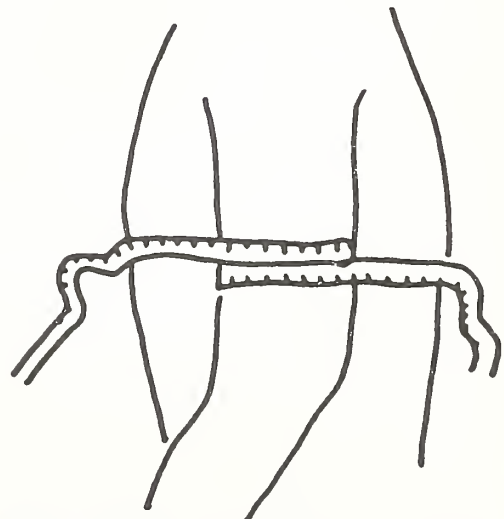


FIGURE 2: Mid-arm muscle circumference

Dr. Gerace, Columbus, Staff Surgeon, and Associate Surgical Program Director, Riverside Methodist Hospital.

Dr. Falcone, Columbus, Chief Surgical Resident, Riverside Methodist Hospital; and Clinical Instructor in Surgery (Division of Plastic Surgery), Ohio State University.

Submitted February 12, 1981.

calorie stores (Fig. 2). Daily weights and calorie counts also can provide an index of nutritional trends in the patient in question. Table 1 provides normal values for the above parameters.

Biochemical tests. — The serum albumin and total lymphocyte counts are a good index of the patient's visceral protein stores (functional proteins). These are part of our routine admission battery and thus easily accessible. The serum transferrin is also a sensitive indicator of visceral protein stores, and a test easily obtained in most hospitals. Using these parameters the degree of biochemical (and, in essence, visceral protein) malnutrition can be determined (using Table 2).

Immunologic status. — The immunologic status of a patient can be determined by delayed hypersensitivity (skin tests), and is another good indicator of nutritional status (assuming other causes of anergy have been excluded). The patient's delayed hypersensitivity also correlates well with surgical morbidity and mortality and can be used as a prognostic indicator.³ defined as no reaction to a standard battery of skin tests (PPD, SKSD, Mumps and Candida antigens). *Relative anergy* is defined as a reaction to one skin test. *Nonanergy* (the normal state) is defined as a reaction to two or more tests.

Nitrogen balance is the goal of nutritional therapy and the end point to nutritional assessment. This is defined as the nitrogen intake minus the nitrogen output.

In persons of normal nutrition and under no stress, the goal of therapy should be to balance nitrogen losses with nitrogen intake (nitrogen balance = 0). In the malnourished or hypercatabolic patient, the goal of therapy should be a nitrogen balance of +4 to +6 (that is to supply 4 to 6 grams of nitrogen daily in excess of bodily losses).

Nitrogen supplied is estimated from the number of grams of protein provided to the patient as enteral or parenteral nutrition. (Remember, there are 6.25 grams of protein for each gram of nitrogen.) The number of grams of nitrogen lost can be determined by obtaining a 24-hour urine collection for urine urea nitrogen (like a BUN done on the urine). This will be reported as grams of nitrogen per 24 hours.

Skin and alimentary tract losses of nitrogen can be estimated as 4 grams per 24 hours and vary very little. For example, a patient receiving 62.5 grams of protein daily while excreting 6 grams of protein daily would have a nitrogen balance of zero.

$$\frac{62.5g}{62.5g \text{ protein/g nitrogen}} - (6g \text{ urinary nitrogen} + 4) = \text{zero.}$$

Most commercial feeding formulas provide standard "ideal" calorie to nitrogen ratios of 150-200 to 1. Therefore, if adequate protein is provided the calories will "take care of themselves." In this way the nitrogen balance can provide a useful way of assessing the actual nutritional needs of a patient and the success of therapy. Other obvious indicators of therapeutic success are weight gain and improvement in weekly nutritional assessment parameters.

Classification of malnutrition. — There are basically two types of malnutrition, *marasmus* and *kwashiorkor*. The marasmic individual has severely depleted stores of nonprotein calories and somatic protein calories as measured anthropometrically. However, the visceral protein stores (such as albumin) as measured biochemically are normal. This type of individual catabolizes his own muscle mass to maintain homeostasis and looks quite malnourished clinically.

On the other hand, the patient with kwashiorkor has relatively normal fat stores and his anthropometric measurements also may be normal. This patient may look quite well-nourished despite having severe visceral protein malnutrition. If a patient demonstrates both forms of malnutrition he is said to have a mixed type of deficiency.

Normal Anthropometric Measurements

Triceps Skin Fold (Adult)

Male	12.5 mm
Female	16.5 mm

Midarm Muscle Circumference (Adult)

Male	25.3 cm
Female	23.2 cm

Jeniffe, D.B., *The Assessment of Nutritional Status of the Community*. WHO Monograph. No. 53. WHO, Geneva. 1966.

TABLE 1

Degree of Malnutrition Based on Biochemical Parameters

	Degree of Malnutrition		
	Mild	Moderate	Severe
Albumin	3.0-3.5	2.5-3.0	2.5 or less
Transferrin	180-200	160-180	160 or less
Lymphocyte count	1500-1800	900-1500	900 or less

TABLE 2

Once the nutritional assessment has been completed by our dietitians, the nutritional support team discusses the data and formulates a plan of therapy. The nutritional assessment then is repeated at weekly intervals to judge the success of therapy and outline required modifications. Figure 3 is an example of the nutritional assessment form we use in our patient evaluations.

Administration

Who to aliment. — This is a decision which requires the clinical judgment that comes with experience. Basically we feel that anyone receiving inadequate protein and calories to meet daily needs should be considered for nutritional support. The healthy patient under mild stress who receives inadequate nutrition for a short period of time (elective cholecystectomy) requires nothing but observation.

However, the premorbidly malnourished, the patient under severe stress, or the patient receiving inadequate nutrition for longer than a week, should have some form of nutritional support. This support may be in the form of nutritional supplements or forced nutrition (enteral or intravenous). We generally use TEN in preference to intravenous hyperalimentation

Riverside Methodist Hospital
Nutritional Support Team Assessment

Name: _____ Diagnosis: _____

Age: _____ Doctor: _____

Height/Weight: _____ cm/kg Room: _____

Ideal Weight: _____ kg Date: _____

In last six months experienced: 1. Chemotherapy
2. Radiation Therapy
3. Surgery
4. Other Stress _____

Weight loss _____ kg in _____ months

Parameters	Patient Values	% of Standard*		
		>90%	60-90%	60% >
Height/Weight	cm/kg			
TSF				
Tricep Skin-fold	mm			
MAC				
Mid-arm Circumference	cm			
MAMC				
Mid-arm Muscle Circumference	cm			
Serum				
gms/100ml	Albumin			
TIBC				
Total Iron Binding Capacity	mcg/100ml			
Total Lymphocytes	mm ³			

*see reverse for standard values

Hgb _____ g/100ml Het _____ % WBC _____ mm³
Hemoglobin Hematocrit White Blood Cell Count

Cell mediated immunity + _____ - _____

Assessment & Plan

Protein Calorie Malnutrition (Marasmus)	Combination of Marasmus & Kwashiorkor
Visceral Protein Depletion (Kwashiorkor)	Normal Nutrition

FIGURE 3: Nutritional assessment form

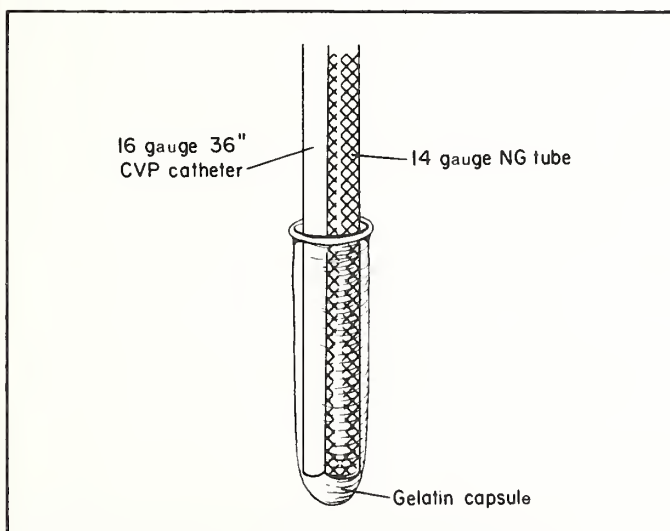


FIGURE 4: A 36 inch intercatch is affixed to an N-G tube with a gelatin capsule.

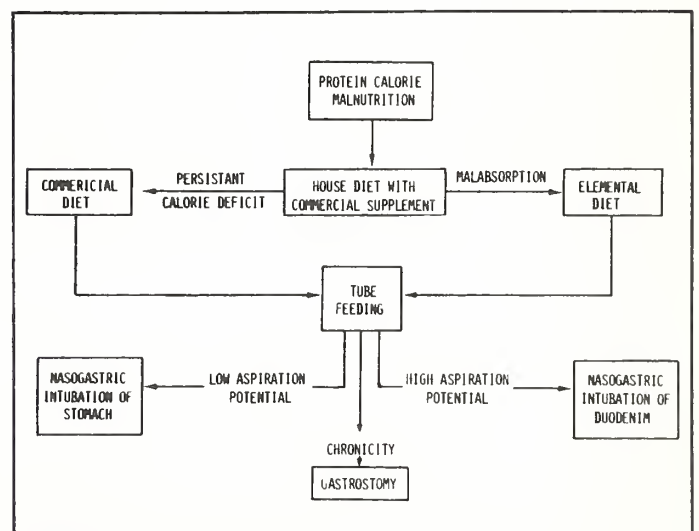


FIGURE 5: Feeding algorithm

when the patient has a functional gastrointestinal tract (see Table 3 for specific indications).

Our only real contraindications are ileus or high aspiration potential. There are also instances in the severely hypercatabolic patient where nutrition cannot be met entirely by enteral means and parenteral nutrition is added supplementally.

How to aliment. — Long-term enteral nutrition necessitates some form of permanent or semipermanent gastrointestinal access. The gastrostomy or jejunostomy tube provides such a function. Although it requires surgery for placement, this frequently can be done under local anesthesia, making it available to all but the most unstable of patients.

A less permanent form of feeding conduit can be provided with a form of nasogastric intubation. The standard NG tube is uncomfortable, promotes aspiration and is not recommended. A 16-gauge, 36-inch intracath provides an excellent form of nasogastric feeding conduit. It can be passed by affixing it to a standard NG tube with a gelatin capsule (fig. 4), passing it into the stomach as with any standard NG tube. After one hour, the gelatin capsule will dissolve, and the NG tube can be removed, leaving the feeding intracath behind.

Commercial feeding tubes such as the Dobhoff and Keofeed tubes also are available. These tubes have weighted ends and can be passed alone or as mentioned above for the intracath. The advantage of these tubes is that with the weighted ends they can be fluoroscopically guided into the duodenum or proximal jejunum, making aspiration less likely. Figure 5 illustrates the choice of feeding conduit.

The standard orders for TEN used at our institution (Table 4) provide a framework for initiating therapy. Once the conduit is in place, its position must be confirmed both clinically and by roentgenogram to avoid aspiration or inadvertent bronchial infusion.

Once a solution is chosen, infusion is started at a continuous rate. Most solutions are somewhat hypertonic and require a weaning-up period to establish tolerance. Two ways to accomplish this include starting with a solution at full strength and gradually increasing the rate (Table 5), or starting with a dilute solution and increasing the concentration and rate of administration independently (Table 6). Tolerance is established by following the patient's blood sugars, urine reductions, and bowel habits. The rate of administration is not advanced in the face of glucoseuria, hyperglycemia, or diarrhea. It is unusual to accomplish more than 3,000 cc of tube feeding in 24 hours (3,000 calories for most commercial solutions).

Once the solution is at an acceptable rate, the infusion is kept constant. The patient's head should be elevated at all times. The infusion should be stopped when the patient leaves the floor for procedures, is placed in a head dependent position, or shows any signs of aspiration. The laboratory data suggested in Table 4 provide a good framework for initiating and following therapy.

Solutions. — Although standard foods can be pureed to a consistency allowing their infusion through a tube, commercially prepared diets often prove more efficient and economical. There are three basic types of enteral diets available: the nonelemental low residue diet, the elemental diet, and the chemically defined diet.

The nonelemental low residue diet is usually a complete diet composed of a protein, carbohydrate and fat source with added vitamins, minerals, and electrolytes. With the exception of occasional personal variation, these diets need no further supplementation, and are the type of diet most often indicated.

Like the nonelemental diets, the *elemental diets* also are usually complete, however, the protein source is usually in the

Indications for TEN

Proximal GI Tract Obstruction

Oropharynx
Esophagus
Stomach or duodenum

GI Tract Dysfunction

Malabsorption
Inflammatory Bowel Syndrome
Short Gut Syndrome

Nervous System Dysfunction

Obtundation with Normal Pharyngeal Reflexes
Obtundation with loss of Normal Pharyngeal Reflexes (gastrostomy or jejunostomy only)
Coma (gastrostomy or jejunostomy only)

Anorexia

Cancer and its treatment
Psychiatric disorders
Chronic disease

TABLE 3

Enteral Hyperalimentation Orders

- Contact dietitian to do nutritional assessment.
- Have _____ enteral feeding tube sent to the floor.
- Portable chest x-ray to ensure catheter placement in stomach.
- Dispense:

Ensure	Vivonex	Osmolite
Ensure Plus	Vivonex HN	
Other:		

 Please circle desired product.
- Enteral feeding to start at: $\frac{1}{3}$, $\frac{1}{2}$, $\frac{2}{3}$, or full strength.
- Begin infusion with rate of _____ ml/hr; container is to hang no longer than 12 hours.
- Maintain infusion rate as prescribed. If rate is ahead or behind schedule, reset to correct rate.
DO NOT TRY TO CATCH UP.
- Type of oral diet: _____
- Daily calorie counts.
- Using glucose and acetone checks every 6 hours, notify M.D. if greater than 2+.
- Sliding scale insulin for urine sugar:

	$\frac{1}{4}\%$	_____ units
(+ 1)	$\frac{1}{2}\%$	_____ units
(+ 2)	$\frac{3}{4}\%$	_____ units
(+ 3)	1%	_____ units
(+ 4)	2%	_____ units
- Notify M.D. if diarrhea occurs.
- Vital signs and temperature every _____ hours.
- Strict intake and output recorded.
- Weigh patient every Monday and Thursday.
- Order trapeze with ambulation.
- CBC with retic count and differential, 12/60, 6/60, serum transferrin, 24° urine for urine urea nitrogen.

TABLE 4

Tube Feeding Schedule No. 1

	Dilution	Rate	Calories/ 24 hrs.*
Day 1	Full Strength	30cc/hr	720
Day 2	Full Strength	50cc/hr	1200
Day 3	Full Strength	75cc/hr	1800
Day 4	Full Strength	100cc/hr	2400
Day 5	Full Strength	125cc/hr	3000

*For solutions providing 1 cal/cc at full strength.

TABLE 5

Tube Feeding Schedule No. 2

	Dilution	Rate	Calories/ 24 hrs.*
Day 1	1/2	50cc/hr	600
Day 2	2/3	50cc/hr	800
Day 3	Full Strength	50cc/hr	1200
Day 4	Full Strength	75cc/hr	1800
Day 5	Full Strength	100cc/hr	2400

*For solutions providing 1 cal/cc at full strength.

TABLE 6

Typical Commercially Available Enteral Solutions

Product Company	Kcal Per Volume	g. N per Volume	mOsm Tonicity	Electrolyte mEq/L.	Nutrient Content Protein Source
Amin-Aid (McGaw)	654/340ml.	0.8g./340ml	900	Less than 2 mEq/pack of Na, K, Ca, Mg	Essential Amino Acids + Histidine useful in Renal failure
Ensure (Ross)	1060/L.	5.8g./L.	450	Na=30, K=31, Cl=29 Ca=25, PO ₄ =0.5mg, Mg=17	Complete, caseinates & Soy Protein
Ensure Plus (Ross)	1500/L.	8.6g./L.	600	Na=43, K=46, Cl=43 Ca=30, PO ₄ =0.6g, Mg=25	Complete, High Cal. High N, caseinates & Soy Protein
Osmolite (Ross)	1060/L.	5.8g./L.	300	Na=23, K=23, Cl=23 Ca=25, PO ₄ =0.5g, Mg=17	Complete, isotonic, caseinates & Soy Protein
Precision Isotonic (Doyle)	1000/L.	4.2g./L.	350	Na=35, K=26, Cl=31 Ca=33, PO ₄ =0.7g, Mg=22	Complete, isotonic, egg albumin
Precision LR (Doyle)	1100/L.	4.2g./L.	525	Na=35, K=26, Cl=36 Ca=33, PO ₄ =0.7g, Mg=22	Complete, Elemental Egg Albumin
Vital (Ross)	1000/L.	6.7g./L.	450	Na=17, K=30, Cl=19 Ca=33, PO ₄ =0.7g, Mg=22	Complete, High Nitrogen, Elemental, Amino Acids & Hydrolysates
Vivonex (Eaton)	1000/L.	3.3g./L.	550	Na=37, K=30, Cl=52 Ca=28, PO ₄ =54, Mg=18	Complete, Elemental Crystalline Amino Acids
Vivonex HN (Eaton)	1000/L.	6.7g./L.	810	Na=33, K=18, Cl=52 Ca=17, PO ₄ =31, Mg=11	Complete, High Nitrogen, Elemental, Crystalline Amino acids

TABLE 7

form of crystalline amino acids. The residue in this type of diet is almost nonexistent. The elemental diet is a good tube feeding choice for the patient with an entero cutaneous fistula, malabsorption or mild inflammatory bowel disease.

The *chemically defined diet* is formulated for a specific purpose — for example, aminade, which is a diet composed of a carbohydrate source and essential amino acids in specific concentration for the patient in renal failure. Table 7 lists a number of commercial diets and their attributes.

Complications

Aspiration. — This potentially fatal complication can be avoided by proper patient and conduit selection. A patient at high risk for aspiration should be fed with a nasoduodenal tube or a nasojejunal tube. This patient should be observed closely and the volume of infusate increased slowly.

The patient who aspirates spontaneously in the absence of feeding should not be fed with a nasointestinal tube. In this case the better choice would be a jejunostomy or parenteral feeding. Once the infusion is initiated, the potential for aspiration also can be avoided by maintaining a constant infusion rate (to avoid an inadvertent bolus of fluid), and by keeping the head of the bed elevated at all times.

Nonketotic hyperosmolar hyperglycemic dehydration. — As with TPN (total parenteral nutrition) this complication is a direct result of glucoseuria and its resultant dehydration. Glucoseuria can be prevented with sliding scale insulin coverage, daily doses of long-acting insulin, or by adding oral hypoglycemics such as Tolbutamide 250 mg to 1,000 mg to each liter of infusate. A constant infusion rate with the prevention of fluid bolus also will tend to minimize hyperglycemia and resultant glucoseuria (a constant infusion pump is ideal).

Diarrhea. — Maintaining a constant infusion rate is the first line of defense. If diarrhea is the result of "dumping," the concentration of solute must be decreased. Another reasonable alternative is to switch to an iso-osmotic solution.

Diarrhea also may occur on the basis of hypoalbuminemia and its resultant malabsorption. Correction requires the administration of parenteral albumin, and a decrease in enteral solute concentration.

If the diarrhea is not caused by the above, then the simplest means of correction is with Lomotil or other similar agents. When using antidiarrheal agents care should be taken to prevent fecal impaction.

Metabolic derangements. — Although most commercial solutions are nutritionally complete, some patients may require additional vitamins or electrolytes. These can be added directly to the solution as needed.

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MEETINGS

Third National Conference on Emotional Stress and Cardiovascular Disease. April 30-May 2; St. John's Inn, Myrtle Beach, South Carolina. Personality Factors in Coronary Heart Disease and the Physiology of Stress will be among the topics discussed. For more information, contact: The American Heart Association, South Carolina Affiliate, P.O. Box 6604, Columbia, S.C. 29260.

First Annual Eastern Tri-Regional Trauma Conference for Physicians and Nurses. May 2-5; Resorts International, Atlantic City, N.J.; 24 hours credit, Category I. For more information, contact: Charles C. Wolfert, M.D., 227 N. Broad St., Philadelphia, Pa. 19102.



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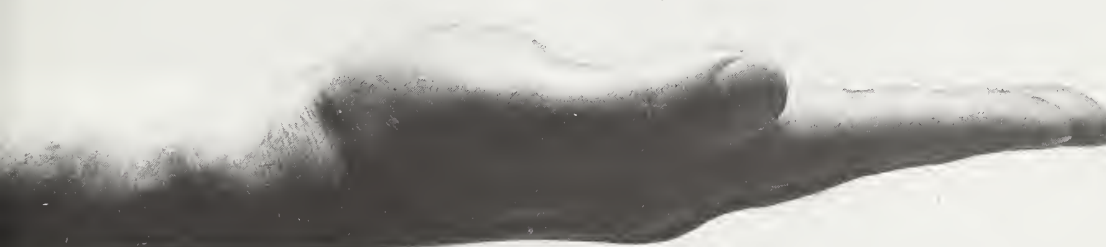
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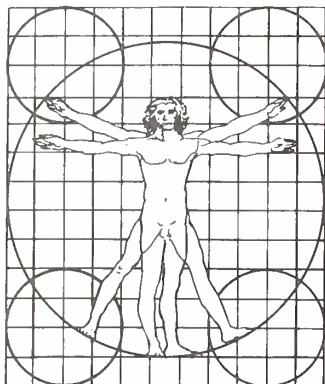


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CLINICAL & SCIENTIFIC

COMMUNITY-BASED GENETIC EDUCATION: SOURCES OF INFORMATION IN A TAY SACHS DISEASE SCREENING PROGRAM

Maureen Clark, R.N., M.S.

Robert Palmer, M.P.H.

Stella Kontras, M.D.

The intent of this study is to explore sources of knowledge and implications for genetic education and counseling of a Tay Sachs Disease Screening Program. Specifically, it describes a recent Tay Sachs Disease Education and Screening Project in Columbus, Ohio, identifies participant sources of information about the project and the disease, and explores implications for future Tay Sachs Disease Programs at Genetic Centers in Ohio.

TAY SACHS DISEASE (TSD), a recessive genetic disease which is fatal and also preventable, is characterized by a progressive central nervous system deterioration due to an in-born error of metabolism. The absence or severe deficiency of a specific enzyme hexosaminidase A (Hex A) results in the accumulation of ganglioside GM2. The accumulation of this lipid material in the cytoplasm results in ballooning and eventual destruction of neurons throughout the nervous system. Patients with TSD have ganglioside GM2 levels 100 to 300 times the normal. Fortunately, screening for possible carriers of this disease can be accomplished by a simple blood test measuring serum Hex A. This enzyme which is significantly reduced (ie, approximately 50%) in carriers, is absent or at very low levels in affected individuals.

TSD is a prototype for the prevention of genetic disease, since tests now are available to determine carrier status and to allow prenatal diagnosis. Protocols for organizing community screening projects and obtaining support and resources for education and testing programs have been developed and have been widely used throughout the United States and Europe since 1970.¹

In the spring of 1980, a communitywide TSD Education and Screening Project was conducted in Columbus, Ohio. The Jewish population, men and women, between 18 and 35 years of age, was selected as at-risk and was estimated to be about 3,000 persons.² This project was the first community-initiated TSD project in the Central Ohio area organized with the assistance and support of the Regional Genetics Center at Children's Hospital, The Ohio State Department of Health (Maternal and Child Health Division), the Jewish Federation, and the Jewish Center of Columbus, Ohio.

Columbus was the only major city in Ohio that had not offered a TSD community education and screening program, although carrier detection tests had been available in the Medical Genetics Laboratory at Columbus Children's Hospital for over three years.

The TSD carrier screening and education project resulted in an initial screening of 75 participants. Twelve TSD carriers, ie, a 16% carrier rate, were detected. The estimated national standard for TSD gene frequency in the United States population is 3% to 6%. Follow-up by leukocyte analysis, a definitive and costly procedure, was performed as a retest of all initial positive and inconclusive results. Further investigation into the characteristics of the population tested and reasons for reported high rates were initiated by the authors at this time.

As with other screening programs, the objective of the Columbus TSD project was to reduce the burden imposed on the family and community by the disease. Genetic disease screening can be accomplished by testing suspected carriers, family history, and mass screening efforts in the community.³ TSD carrier testing is an established laboratory procedure practiced frequently, for the benefit of thousands. Unfortunately, it is a costly and technically difficult test to perform on more than a small percentage of the population at a given time. As a result, it has been suggested by Kaback³ and others that priority be given to those persons at highest risk for being carriers, ie, "near relatives, 18 to 40 years of age, of patients with lipid storage disease, and partners of consanguineous marriages."³

Although TSD carrier detection screening provides a prototype for the prevention of a variety of genetic diseases, it is a costly procedure.³ With limited resources, and an increase in the number of diseases being screened, it is apparent that strategies for ascertaining screening priorities must be deter-

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Submitted March 3, 1981.

mined.^{4,5} The population at greatest risk must be reached by the most cost-effective means.^{6,7} In addition, segmentation of the targeted population needs to be an integral part of any screening and education program. This study sought to (1) determine what influenced persons to participate in the Columbus TSD program;⁸ (2) assess knowledge of basic human genetics in the participants;⁸ and (3) make recommendations for future TSD screening efforts in Ohio for the network of genetic centers in Ohio and the Jewish Center in Columbus.

Method

The level of general knowledge of TSD and its genetic transmission was determined by reviewing the results of a TSD quiz administered to approximately 70 participants in the Columbus Area TSD Screening and Education Project (1980). Prior to screening, demographic data including parity, source of medical care, country of origin, and parental ancestry were analyzed to determine communication channels reported and used. A comparison of information sources was made by a review of the literature related to other screening efforts such as hypertension and sickle cell anemia. Our supposition that informal sources of health information, ie, friends, relatives, are more effective than formal channels of communication, ie, television, radio, and physicians, in reaching a targeted population identified for potential screening and community education efforts, is demonstrated in the table.

The Population

Of the 72 persons who participated in the Columbus Tay Sachs Screening Program, 91.6% were Ashkenazi Jews between 18 and 35 years of age. Ninety-six percent had no known history of TSD. More than half were married (68%) and only a third had any children. Similar to other participants in TSD screening programs in the United States, this population was predominantly college graduates (66%) who represented most professional and managerial occupations.^{3,9}

These participants appeared well-informed about TSD as ev-

idenced by the high test scores received on a questionnaire distributed during the registration process (85.3% of the men and 92.2% of the women answered correctly). In contrast, their knowledge of human genetics and modes of inheritance revealed low test scores, with more than half of the men and women participants answering the questions incorrectly (52.9%, 50% respectively).

Results

In the initial serum assay screening of 72 Columbus participants, 11 or 16% reports were either inconclusive or positive carriers. With a national TSD carrier frequency rate of 3% to 6%, these high initial results were unexpected. All participants were notified of their carrier status and those who had received positive or inconclusive results were encouraged to contact the Genetics Center for further counseling and testing. Husbands of pregnant women were tested and processed immediately. One of the 11 chose not to have further testing. Ten of them sought more information and testing by leukocyte analysis. Time was set aside so that some of the same laboratory and education staff could be available for counseling. The counseling and laboratory fees were subsidized by the Genetics Center and the Mt. Sinai Hospital in Cleveland assisted in the processing of specimens.

The follow-up leukocyte assay resulted in the detection of two TSD carriers, one man and one woman. Each was contacted personally by the Genetics Center Director and follow-up letters were sent to them and their family physicians. Further genetic counseling and testing of other family members were offered then and for the future, since neither carrier had children and only one was married at the time of the testing.

Further investigation into the initial high incidence rate which included both positive and inconclusive findings (16% Columbus versus 3% to 6% U.S.) of the initial serum testing, was conducted with the assistance of the epidemiologist at Columbus Children's Hospital. Results indicated that 95% of the participants were Ashkenazi Jews and had listed their parents' country of origin as either Poland or Russia. This finding was significant since it is known that TSD occurs 100 times more frequently in Ashkenazi Jews than in other Jewish groups and non-Jewish population.

On reviewing the participants' medical histories for pre-existing medical problems which might have affected the reported TSD carrier rate in Columbus, it was found that there was no evidence of liver disease, chronic illness, or current medication use which could account for some suspected false positive results. In the follow-up leukocyte screening a month later, only two carriers were detected. All four persons of the 10 who initially had inconclusive results, proved *not* to be carriers. The two carriers detected had had positive results in both the serum (first) and leukocyte (second) screenings. None of the 10 had children. One half were married, all were of Ashkenazi Jewish origin, and ranged in age from 24 to 48 years of age.

TAY SACHS DISEASE INFORMATION SOURCES (COMBINED MALE AND FEMALE RESPONSES)

COLUMBUS (CLARK, 1980) N = 72		LOS ANGELES (MASSARIK, 1973) N = 801	
Posters	55%	Posters	N/A
Newspapers	29%	Newspapers	28%
Friends	26%	Friends	25.5%
Scientific Literature	11%	Scientific Literature	9.6%
Relatives	20%	Relatives	8.7%
Physician	9.7%	Physician	8%
School	5.5%	School	5.0%
Magazine	5.5%	Magazine	26.5%
TSD Family	4.0%	TSD Family	12.5%
Television	0%	Television	42%

(Percentages do not add up to 100% because of multiple possible answers.)

Conclusion

Initial serum screening is an efficient and economical procedure to employ for use in mass screening programs. However, the anxiety and concerns of those participants diagnosed as positive or inconclusive carriers who then underwent a month's delay and further testing, must be considered in future programs. The results of this program have been shared with the Jewish community and TSD testing continues to be available upon request. Future public awareness efforts will focus on distributing TSD brochures to offices of pediatricians and obstetricians and to schools. None of the population in the second screening had children. Thus, with the detection of even two carriers in a community this size, a tool now has been provided for the prevention of a future tragedy.

Reaching the population at greatest risk by the most effective means needs to be an integral part of any screening and education program. Involving those individuals who are personally susceptible and therefore most vulnerable to potentially harmful information requires, in addition, a sensitivity to issues such as: What do they understand their risks to be as TSD carriers? Who or what has influenced them to participate in a screening program? And most important, how is this information going to improve the quality of life for them and their families?

The Columbus experience was an example of a response by the medical community to provide information and testing to a special segment of society which wanted to assume more responsibility for their own health, and perhaps even more importantly, for the health of those yet to be born.

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Council Minutes (continued)

position but provide technical assistance.

H.B. 703; police/prisoner emergency care — no position but provide technical assistance.

DRUNKEN DRIVER

LEGISLATION; — expressed opposition to drunken driving and offered technical assistance with legislation.

H.B. 565; Medical Licensure — The OSMA recognizes the national problem of unaccredited foreign medical schools and believes this national problem should be addressed by a national solution. As an interim measure in the absence of a national solution, the OSMA supports a state program of evaluation of the individual licensure applicants from these schools, rather than evaluation and approval of the schools themselves by a state agency — **this position was approved 8 - 7.**

The report was filed.

The Council authorized the President to appoint an ad hoc committee to study problems and implications of clerkships and graduate medical education programs in Ohio hospitals, offered to graduates of "proprietary" and nonaccredited medical schools. Dr. Dunsker appointed Dr. Kilroy, Chairman, Dr. Spragg, Dr. Pfahl, and Dr. Yut.

Mr. Burkland and Mr. Campbell

reported that the Joint Underwriting Authority Board of Governors has voted to support H.B. 664, the J.U.A. bill. The bill has been amended by the Board to eliminate language providing for immediate return of funds to Ohio physicians and hospitals.

Mr. Burkland reviewed other measures pending before the legislature.

Committee on Association Structure

— Dr. Albers presented a resolution on Representation of Specialty Societies in the OSMA House of Delegates.

The Council amended the resolution and voted to present it to the House of Delegates. (Dr. Yut dissenting.)

The Council voted to present a resolution to amend Section 1, Chapter 15 of the Bylaws to permit methods rather than or other than publication in the *Ohio State Medical Journal* with regard to notice of proposed amendments to the OSMA Bylaws.

Department of Communications

Ms. Doll presented the written report of the Department of Communications.

The report was filed.

Committee on Art and Culture — The December 9, 1981 minutes of the Committee on Art and Culture were filed.

Ohio State Medical Journal — Sylvan Weinberg, M.D., Dayton, addressed the Council concerning his suggestion for the *Ohio State Medical Journal*.

The Council authorized the President to appoint a publications committee of Councilors. He appointed Dr. Barr, Chairman, Dr. Kilroy, Dr. Yut, Dr. Kloss and Dr. Albers.

Dr. Weinberg's recommendations were referred to the Publications Committee for study and evaluation.

Department of Field Service

Mr. Holcomb presented his department report for information.

Task Force on Competition and Marketing — Mr. Holcomb presented a progress report on the January 21, 1982 meeting of the Task Force on Competition and Marketing.

The report was filed.

Councilor Reports

The Councilors reported on the activities in their respective districts.

Legal Counsel Report

Mr. Pohlman presented the report of legal counsel.

Proposed amendments to the Auxiliary Bylaws were approved by the Council.

Ohio Department of Health

Ohio Director of Health, John H. Ackerman, M.D., addressed the Council.

He discussed budget cuts and their effects on the department's operation.

He discussed proposed legislation on radiation safety problems currently being studied by the OSMA Committee on Legislation and a bill concerning low-level radioactive wastes.

OSMA Auxiliary Report

Mrs. A. Robert Davies, President, presented an interim report from the OSMA Auxiliary.

The report was filed.

There being no further business, the meeting was adjourned.

ATTEST: Hart F. Page, CAE
Executive Director



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*PATIENT CARE Magazine—Outlook 1977 "Face-Off: Cost Containment vs. Chaos," January 1, 1977

Lyle CB, et al "Practice habits in a group of eight internists," ANNALS OF INTERNAL MEDICINE 84 (May 1976), 594-601.

Schroeder SA, et al "Use of laboratory tests and pharmaceuticals: variation among physicians and effect of cost audit on subsequent use," JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION 225 (Aug. 20, 1973), 969-73.



Annual Meeting Preliminary Schedule (continued)

District 11, Room 205, CC

District 12, Room 206, CC

House of Delegates

Registration 3 - 5:30 PM

Outside Assembly Hall, CC

Sit-down dinner 5:30 PM

Van Cleve I & II, ST

Opening Session 7 - 9 PM

Assembly Hall, CC

Following House of Delegates

Montgomery County Medical Society Glee Club

Auditorium, CC

After the Glee Club

Reception — sponsored by Montgomery County Medical Society
and the county societies comprising District 2

Van Cleve I, ST

Physical Medicine & Rehabilitation

Luncheon 12 NOON

Van Cleve IV, ST

Meeting 2 - 5 PM

Room 207, CC

Psychiatry

Luncheon 12 NOON

Glenn Room, SH

Meeting 1 - 5 PM

Wright Brothers, SH

House of Delegates

Registration 11:30 AM - 1 PM

Outside Assembly Hall

Final Session 1 PM

Assembly Hall, CC

Sit-down Dinner 6 PM

Van Cleve I & II, ST

Resume Final Session 6:45 - 8 PM

Assembly Hall, CC

Internal Medicine

1 - 5 PM

Meeting

Room 204, CC

Anesthesiology

1:30 - 4:30 PM

Meeting

Room 202, CC

Ophthalmology

Scientific Session 2 - 5 PM

The Theatre, CC

Dinner 5 - 9 PM

Regency Ballroom, SH

Monday, May 3

Ophthalmology

Business Meeting 8 - 10 AM

The Theatre, CC

Board Meeting/Breakfast 8 - 10 AM

Van Cleve IV, ST

Business Meeting 10 - 11:30 AM

The Theatre, CC

Luncheon/cocktails 11:30 AM - 1:30 PM

Regency Ballroom, SH

Scientific Session 1:30 - 5 PM

The Theatre, CC

OSMA Council

8:30 AM

Meeting/Breakfast

Van Cleve III, ST

Ohio Committee on Trauma, A.C.S.

9 AM - 12 NOON

Scientific Session

Room 207, CC

Sports Medicine

Meeting 9 AM - 12 NOON

Room 303, CC

Luncheon 12 NOON

Van Cleve I & II, ST

Meeting 1 - 4 PM

Room 303, CC

Wright State Day

9 AM - 4 PM

Rooms 304 & 305, CC

PICO

10 AM

Shareholders Meeting

Room 204, CC

Saturday, May 1

Reference Committees

Breakfast 6:30 - 7:30 AM

Van Cleve I & II, ST

Hearings 7:30 - 11:30 AM

Committee No. 1, Room 302, CC

Committee No. 2, Room 303, CC

Committee No. 3, Rooms 304 & 305, CC

Committee No. 4 & President's Address, Room 202, CC

Nominations, Room 306, CC

into Executive Session 1:30 PM

Same rooms used earlier

Drafts & Reports 9 PM

Prepared and Reviewed by Committees

Same rooms used earlier

OMPAC

Board Breakfast 8 AM

Plaza XIV, ST

Social Hour & Luncheon 11:30 AM - 1:30 PM

Van Cleve, ST

PICO

Update Meeting — Room 203, CC 1:30 - 2:30 PM

Medical Mutual

Reception — Van Cleve II, ST 3 - 5 PM

OMIM

Reception — Van Cleve I, ST 5 - 6:30 PM

Sunday, May 2

District Caucus

9 AM

Meetings (reports ready)

District 1, Room 302, CC

District 2, Room 203, CC

District 3, Room 306, CC

District 4, Room 204, CC

District 5, Room 303, CC

District 6, Room 207, CC

District 7, Room 307, CC

District 8, Room 308, CC

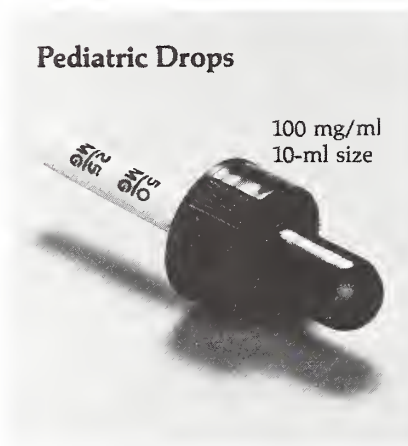
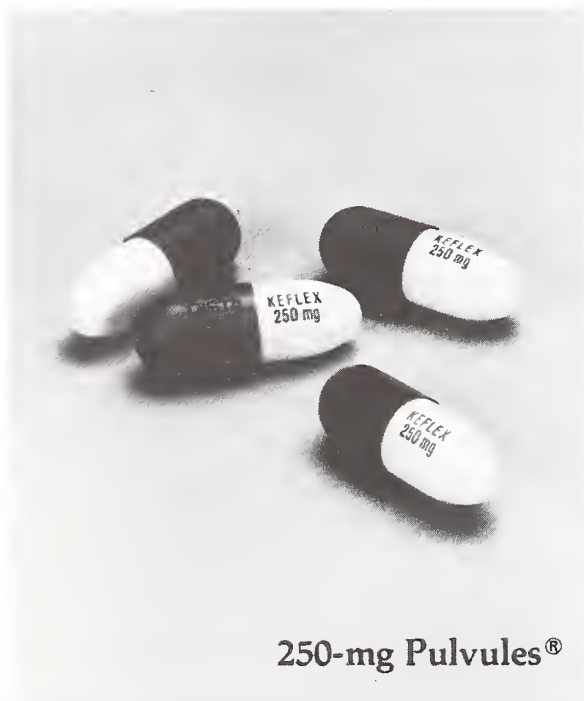
District 9, Room 309, CC

District 10, Room 202, CC

District 11, Room 205, CC

District 12, Room 206, CC

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Rheumatology		Pathology	9 AM - 4:30 PM
Luncheon	12 NOON - 1:15 PM	Meeting	
Van Cleve III, ST		Room 302, CC	
Meeting	1:30 - 5 PM	Colon and Rectal Surgery	
Room 204, CC		Luncheon	11:30 AM - 1 PM
Emergency Medicine	1 - 5 PM	Room 304, CC	
Meeting		Meeting	1 - 5 PM
Room 207, CC		Room 203, CC	
Pathology	4:30 - 6 PM	Family Practice	
Board of Governors Meeting		Meeting	2 - 5 PM
Room 306, CC		Room 202, CC	
Neurosurgical	7 PM		
Dinner			
Dayton Racquet Club			

Tuesday, May 4

Neurosurgery	
Breakfast	7 - 8:30 AM
Van Cleve III, ST	
Meeting	8:30 AM - 12 NOON
Rooms 304-305, CC	
Luncheon	12 NOON
Van Cleve III, ST	
Meeting	1:30 - 5 PM
Rooms 304-305, CC	

Wednesday, May 5

Plastic Surgeons	9 AM - 12 NOON
Meeting	
Van Cleve I, ST	
Luncheon	12 NOON
Van Cleve III, ST	
Allergy & Immunology	8:30 AM - 12 NOON
Meeting	
Van Cleve II, ST	
Luncheon	12:30 PM
Daytonian	

Resolutions (continued)

discussion, deems the 1982 House of Delegates weekend format reasonable; therefore be it RESOLVED, That OSMA House of Delegates format of Friday, Saturday and Sunday be tried for 3 years and reevaluated.

Introduced by:

The OSMA Council

Subject:

Bylaw Amendment Procedure

Whereas, OSMA Council believes that revision of the OSMA Bylaws to provide for direct notice to members of proposed changes in the Bylaws is appropriate, it recommends for adoption by the House of Delegates the following: RESOLVED, That the OSMA Bylaws, Chapter 15 ("Amendments"), Section 1 ("Method of Amending") be amended to provide as follows: Section 1. Method of Amending. These Bylaws may be amended at any Annual Meeting of the House of Delegates by a majority vote of the delegates present at that

session, provided that the proposed amendment shall have been published in *The Journal* OR MAILED TO ALL MEMBERS OF THE ASSOCIATION at least thirty (30) days prior to the Annual Meeting.

Introduced by:

The OSMA Council

Subject:

OSMA Committees

Whereas, OSMA Council believes that revision of the OSMA Bylaws to provide the opportunity for more members to become involved in OSMA activities, it recommends for adoption by the House of Delegates the following: RESOLVED, That the OSMA Bylaws, Chapter 9 ("Committees"), Section 2 ("Appointment") to be amended to provide as follows: Section 2. Appointment. The President with approval of Council shall appoint the chairman and members of each standing and special committee. EACH COMMITTEE CHAIRMAN SHALL

SERVE A ONE-YEAR TERM, AND MAY SERVE A MAXIMUM OF TWO CONSECUTIVE ONE-YEAR APPOINTMENTS. A COMMITTEE CHAIRMAN WHO HAS SERVED TWO ONE-YEAR APPOINTMENTS IS ELIGIBLE FOR REAPPOINTMENT AS CHAIRMAN AFTER ONE YEAR. THE LIMITATIONS ON YEARS OF SERVICE AS CHAIRMAN SHALL NOT AFFECT THE MEMBER'S RIGHT TO BE APPOINTED TO SERVE ON ANY COMMITTEE. EACH COMMITTEE MEMBER SHALL BE APPOINTED FOR A TWO-YEAR TERM, except for the first appointments at which time one half of the committee shall be appointed for one year and one half of the committee shall be appointed for two years. EACH COMMITTEE MEMBER IS LIMITED TO THREE CONSECUTIVE TWO-YEAR TERMS ON ANY ONE COMMITTEE. A MEMBER HAVING SERVED THE MAXIMUM OF THREE CONSECUTIVE TWO-YEAR TERMS IS ELIGIBLE FOR REAPPOINTMENT TO SUCH COMMITTEE AFTER ONE YEAR.

A MEMBER MAY SERVE ON MORE THAN ONE COMMITTEE SIMULTANEOUSLY. IF A VACANCY OCCURS IN ANY COMMITTEE, the President with approval of Council, MAY fill the vacancy for the remainder of the term.

Submitted by:

Victor G. Sonnino, M.D.

Subject:

Establishment of a Resident Physician's Section Within the OSMA

WHEREAS, The number of AMA and OSMA resident physician members has been steadily increasing; and, WHEREAS, More and more resident physicians are becoming active in their Housestaff Associations, county medical societies, and in the broader aspects of organized medicine; and, WHEREAS, The AMA Resident Physician's Section has become a strong and vital member of the AMA House of Delegates with full voting privileges and a position on the AMA Board of Trustees; and, WHEREAS, There is a need for continuous and active communication between the various aspects of the medical profession to assure a strong medical society, ready to meet the ongoing challenges of our changing times; THEREFORE, BE IT

1. RESOLVED, That a Resident Physician's Section within the OSMA be formed to provide a forum within the state association for the exchange of information among young physicians in training and their Senior colleagues and, BE IT FURTHER
2. RESOLVED, That the OSMA Constitution, Article VII, ("The Council"), shall be amended to provide as follows:
The Council shall consist of one councilor from each councilor district, ONE RESIDENT FROM THE RESIDENT PHYSICIAN'S SECTION, one non-voting students member from the

Medical Student Section and the other elected officers of this Association. The Council shall be the executive body of this Association and it shall have the complete custody and control of all funds and property of this Association and shall have and exercise full power and authority of the House of Delegates between meetings of the House of Delegates, and BE IT FURTHER

3. RESOLVED, That the OSMA Bylaws Chapter 7, ("The Council") Section 4, ("Individual Duties of Councilors") shall be amended to provide as follows:
Each Councilor shall be the organizer, peacemaker and censor for his district. He shall visit each county in his district at least once each year for the purposes of inquiring into the condition of the profession and of each component society in his district and of keeping in touch with the activities of each of such societies. In every disciplinary matter involving a member of a component society located in the Councilor's district, the Councilor, in advance of a hearing on any charges filed against such member, shall make every effort to effect a conciliation or compromise consistent with honor and the principles of medical ethics. The duties of the non-voting Councilor from the Medical Student Section shall be set forth in the Bylaws of said section. THE DUTIES OF THE COUNCILOR FROM THE RESIDENT PHYSICIAN'S SECTION SHALL BE SET FORTH IN THE BYLAWS OF SAID SECTION.

WHEREAS, The Consitution and Bylaws of the OSMA have been amended to create a Resident Physician's Section; THEREFORE, BE IT

RESOLVED, That pursuant to the OSMA Constitution, Article IV, ("House of Delegates") Subsection (5) The Resident Physician's Section shall elect twelve representatives to

the House of Delegates, or a number equal to the established OSMA Councilor Districts, commencing with the Annual Meeting in 1983. The said delegates are to be selected in accordance with the Bylaws of the Resident Physicians Section to be approved by Council, BE IT FURTHER RESOLVED, For purposes of representation in the House of Delegates, resident members shall not be counted at the individual district level but shall constitute a separate section which shall be treated and seated as if it were an additional district in which the resident members of the resident physician's section would elect their own delegates.

Physician-owned insurance companies receive support

"The honeymoon is over for the physician-owned companies writing medical liability insurance and the long tail on claims has arrived," said James Sammons, M.D., Executive Vice President of the American Medical Association, at a forum for Medical Affairs held recently in Las Vegas.

Although the frequency and severity of claims are increasing at an alarming rate, Dr. Sammons urged the continued support of physician-owned companies because "they will be there when you need them."

Liberal courts, higher limits of claims, and higher costs for medical liability insurance were cited as partly to blame for the recurring crisis. The fact that physicians can no longer pass the cost of medical liability insurance on to the patient is another area of concern.

"We are looking at a fixed fee market whether we like it or not," says Arthur Mannix, M.D., President of the Liability Mutual Insurance Company of New York.

Currently, 45% of the national market is covered by physician-owned companies, and the American Medical Association Insurance Company is providing reinsurance for 45,000 U.S. physicians.

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Employment Opportunities

ANESTHESIOLOGIST, OSU grad, licensed in Ohio, board certified, mature, wide experience. Seeks position N-East Ohio within an hour or so of Akron. Reply to Box No. 930, c/o Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

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Contraindications: Known hypersensitivity to drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) reported after abrupt cessation of extended use of excessive doses are similar to those seen with barbiturates. Milder symptoms reported infrequently when continuous therapy is abruptly ended. Avoid abrupt discontinuation; gradually taper dosage.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship has not been established clinically. Due to isolated reports of exacerbation, use with caution in patients with porphyria.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction, changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. **Oral—Adults:** Mild and moderate anxiety disorders and symptoms, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. **Geriatric patients:** 5 mg b.i.d. to q.i.d. (See Precautions.)

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Telephone: 203/661-9702

Regional

The Ohio State Medical Journal
600 South High Street
Columbus, Ohio 43215
Telephone: 614/228-6971

Address All Correspondence, Address Change, & Reprint Request (unless otherwise noted): Executive Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215. Phone: 614/228-6971.

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1981 Subscription: \$15 per year, single copy \$2 (outside U.S. \$20 and \$3).

Send address changes to: The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second Class Postage paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by
The Lawhead Press, Inc., Athens, Ohio



Letters ...to the editor

Participating agreements

To the Editor:

"OMIM's Participating Agreements, A Personal Decision" initiated some interest recently at our Licking County Medical Society meeting. I would like to add one more undesirable characteristic to the participating agreements.

Blue Cross and Blue Shield have different geographical regional reimbursement areas across Ohio. These regional fee scales may be undesirable to the rural physicians of Ohio. A resolution regarding this matter was initiated at the 1981 OSMA meeting.

Sincerely,

/s/Keith R. Kulow, M.D.
Newark, Ohio

(The OSMA Journal welcomes letters from its readers. Please address all letters to: Executive Editor, 600 S. High St., Columbus, Ohio 43215. Letters may be edited to meet space requirements.)



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SECOND OPINION

Let's lead the way to low-cost care

Walter K. Chess, M.D.

Recently I saw an article in the AMA News by John Markey, M.D., in which he discussed the leadership potential of those of us in the medical profession. He says we are committed to offer the public the very best medical care possible in the most cost-conscious, cost-efficient manner.

Dr. Markey states, and I fully agree, "We must make patients aware of the cost of medical care." We, as well as our patients, are citizens of this country and must do all we possibly can to see that in the process of rendering high quality medical care, we also do all we can to preserve the economic health of the country.

At this moment we could be presented with an opportunity to show how committed we are to the obligation of being "good citizens."

Item: Our national mood is being led by an administration and legislatures who realize the self-destruction economics of the past 30 or so years must be changed if we are to endure and succeed as the true leaders of the free world.

Item: The crippling inflation rate has started to show some improvement which will soon be apparent to every citizen.

First, we all have seen situations where we could order all of the possible diagnostic tests from sed rates to cat scans. Are these tests really always necessary or even advisable?

Someone, after all, does have to pay for these whether it is private or government insurance coverage. We all know the ways these costs are reflected in insurance rates or worse

"How about . . . voluntarily lowering our fees by, say, ten per cent?"

Item: The nation's larger labor unions have finally realized that constantly escalating wage demands must be reversed and are renegotiating existing contracts or consenting to voluntary wage reductions.

Item: The unemployment rate stands at a very undesirable level of almost 9%.

Item: The C.P.I. is showing reduction in most factors with medical costs being the largest single increase.

Item: Our president, on January 14, 1982, earnestly solicited the help of private facilities and organizations to supply some of the needs of this country that have been supplied by the government in the recent past.

Now, what could we do to be a major factor in helping our nation, our families, and possibly assure better lives for our grandchildren?

yet, taxes. Could we each be a little more judicious in our orders? I think we could. We also might try to explain to patients the economic reality of diagnostic tests.

How about following the example of other segments of our economy in voluntarily lowering our fees by, say, 10%! We all know that private practitioners' fees amount to only 18%-20% of the overall medical costs, but a fee reduction could be a catalyst to other actions.

Can you imagine the pressure which would be applied to insurance companies and hospital administrations to follow the lead of the major health professionals? Also, can you imagine the reaction of our media "analysts"?

It seems to me that an honest, widely accepted, voluntary reduction of our fees would be an act of real leadership and show some economic responsibility. As an aside, I could assure everyone it would **not** send any of us to the poor house.

If we, as citizens, really care about our country regaining economic vitality, these actions could really help.

Do we have the intestinal fortitude to attempt such actions?

Walter K. Chess, M.D., is a member of the OSMA and practices in New Concord, Ohio.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-pubertal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg. Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpubertal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D. Hormones for Improved Sexuality in the Male and the Female Climacteric, *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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COLLEAGUES IN THE NEWS



The following received awards for serving on St. Charles Hospital's medical staff for 25 years: **ROLAND A. GANDY, M.D.**, general surgery; **HARVEY C. GUNDERSON, M.D.**, otolaryngology; **JEROME KIMMELMAN, M.D.**, dermatology; **MICHAEL LINVER, M.D.**, anesthesiology; **OJARS PODINS, M.D.**, family practice; **MARTIN REINER, M.D.**, family practice; **PAUL K. RIDENOUR, M.D.**, family practice; **RICHARD L. SCHAFER, M.D.**, hematology/oncology; **ERIC H. SCHMIDT, M.D.**, general surgery; **JAMES G. SULLIVAN, M.D.**, plastic surgery; and **WILLIAM A. WINSLOW, M.D.**, family practice.

The following Columbus physicians are the new officers for the 1981-1982 board of trustees for Peer Review Systems, Inc.: **PHILIP H. TAYLOR, M.D.**, chairman; **J. HUTCHISON WILLIAMS, M.D.**, president; **WILLIAM A. SMITH, M.D.**, vice president; **CAROLYN ZIEGLER, M.D.**, secretary; and **WILLIAM T. PAUL, M.D.**, treasurer.

The following were elected to the board of trustees: **DUDLEY BRIGGS, M.D.**, medical director of Western Electric; **STEWART CHASE, M.D.**, Mercy Hospital; **DONALD P. DUNN, M.D.**, president of Plaskolite, Inc.; **ROY R. MILLER, M.D.**, Riverside Methodist Hospital; **JUDSON MILLHON, M.D.**, Riverside Methodist Hospital; and **CAREY B. PAUL, M.D.**, Mt. Carmel Medical Center.

SIDNEY A. PEERLESS, M.D., Cincinnati, was named chairman of the 1982 Jewish Welfare Fund. Dr. Peerless is director of otolaryngology at Jewish Providence Hospitals, and assistant professor of otolaryngology and maxillofacial surgery at the University of Cincinnati College of Medicine.

JOHN SCHAEFFER, M.D., Amherst, was elected chief of medicine of Lorain Community Hospital.

I. LEONARD BERNSTEIN, M.D., Cincinnati, was named president of the American Academy of Allergy. Dr. Bernstein is director of the Allergy Research Laboratory, Allergy Training Program, Division of Immunology and clinical professor of medicine at the University of Cincinnati Medical Center.

CATHERINE TABB, M.D., Louisville, was appointed chairman of the medical records committee at Molly Stark Hospital. Dr. Tabb is on the staff at Aultman hospital and serves as physician to the student nurses.

ROBERT G. THOMAS, M.D., Elyria, will replace the late Roy E. Hayes, M.D., on the board of directors of the Greater Lorain County Community Foundation. Dr. Thomas, a pathologist, is director of laboratories for Elyria Memorial Hospital. He is a former president of the Ohio State Medical Association and serves on a number of committees for the College of American Pathology.



Robert G. Thomas, M.D. . . . now serving on the Board of Directors, Elyria Hospital.



I. Leonard Bernstein, M.D. . . . new President of the American Academy of Allergy.

"Colleagues in the News" is sponsored by



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Colleagues (continued)

ALVIN H. CRAWFORD, M.D., Cincinnati, recently returned from Amman, Jordan where he was visiting professor in orthopedics at the King Hussein Medical Center. Dr. Crawford was received by His Royal Majesty King Hussein and agreed to coordinate the development of a Scoliosis and Spinal Deformity Center at the Farah Royal Jordanian Rehabilitation Centre.

FRED L. TASKER, M.D., Sandusky, was elected president of the Good Samaritan Hospital medical staff. Also elected were **JOHN COOK, M.D.**, vice-president, and **ROBERT SAWICKI, M.D.**, treasurer.

W. HUNTER VAUGHAN, M.D., Steubenville, was elected chief of the St. John Medical Center medical staff. Dr. Vaughan is a radiologist. **NICK TEREZIS, M.D.**, was elected chief of staff-elect.

ROBERT WALLACE, M.D., was elected president of the Lakewood Hospital medical staff. Also elected were **WILLIAM KAYLOR, M.D.**, vice-president, and **JOHN SYLVESTER, M.D.**, secretary-treasurer.

PAUL R. ZEIT, M.D., Burton, was elected president of Hillcrest Hospital's medical staff and chairman of the medical council. Also elected were: **THOMAS H. REDDING, M.D.**, president-elect of the medical staff and chairman-elect of the medical council; **BENEDICT COLOMBI, M.D.**, secretary of the medical staff; and **NORMAN BASH, M.D.**, treasurer of the medical staff.

RALPH A. STRAFFON, M.D., Cleveland, was reelected to the Board of Directors of the Council of Medical Specialty Societies.

JOHN C. MELNICK, M.D., Youngstown, received the fourth annual "Doctor of the Year" award of the Mahoning County Medical Society. Dr. Melnick directs the department of radiology and nuclear medicine at Youngstown South Side Hospital and is vice-chief of the division of radiology at YHA, and an associate professor of radiology at North Eastern Ohio Universities School of Medicine.

WILLIAM E. SOVIK, M.D., Youngstown, was reelected clinical staff president of St. Elizabeth Hospital Medical Center. Also reelected were **WILLIAM CRAWFORD, M.D.**, vice-president, and **RICHARD S. RICHARDS, M.D.** secretary-treasurer.

GEORGE E. SPENCER, JR., M.D., Cleveland, is the new president-elect of the Clinical Orthopaedic Society.

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INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyoderms (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically* the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neo-



mycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section). Complete literature available on request from Professional Services Dept. PML.



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NEWS

a compilation of the latest developments, reports and products of interest to physicians.

**edited by
Gina DiBlasio Cummins**

Hypertension or tension?

Patients whose blood pressure rises to an all-time high in your office may be experiencing closer-to-normal readings while in their own homes.

Such was the conclusion drawn by Thomas G. Pickering, M.D., of the N.Y. Hospital-Cornell Medical Center, New York City, based on a study he conducted on 24-hour blood pressure recordings.

The study, written up in a recent issue of the *Journal of the American Medical Association*, attributes the higher readings in physicians' offices to a defensive reaction triggered by anxiety or nervousness. The effect of being labeled "hypertensive" could also be responsible for increasing the level of anxiety of such individuals when they next visited their physicians' offices for blood pressure measurement.

As a result, however, Dr. Pickering feels that physicians may be receiving a false impression of the severity of hypertension.

He suggests that a 24-hour blood pressure recording may be helpful in determining whether or not treatment is warranted in people with mild or borderline hypertension.

"Pro-competition" health legislation is edging closer to reality

The "pro-competition" health legislation which the Administration has been promising as a means of ending regulation in the health care field is moving along, slowly but surely, to realization.

In remarks recently delivered in Washington, D.C., Secretary of Health Richard Schweiker reported that the President's competition task force has developed the following basic options for consideration:

1. Limits on the amount employers can deduct against income taxes for health insurance premiums. A possible cutoff on employer tax deductions has been suggested of \$150 per month for an employee with family coverage and \$60 per month for individual coverage. Companies currently contributing amounts above these limits would be allowed to continue contributions at their current rates without penalty.

2. Consumer choice. Employers would be offered tax credits — perhaps equal to a fraction of start-up costs — for moving from single-plan to multiple-plan arrangements. Except for certain preventive services, which would be exempt, a 20% coinsurance would have to be imposed on the services of all plans, with a limit on out-of-pocket costs in any year of not more than \$3,500 per family.

Employers would have to make the same premium contribution to all plans offered.

Employees choosing a plan costing less than the employer contribution would get a tax-free cash rebate, limited to some percentage of the difference between the premium of the high-option plan and the plan actually selected.

3. Imposition of a 10% Medicare coinsurance on all hospital days after the first, with an indexed \$2,500-per-year limit on cost sharing under both Parts A and B of Medicare. The existing limits on the number of covered hospital days under Medicare would be removed.

4. Voucher system under Medicare. The federal government would offer to pay 95% of Medicare's adjusted average per capita cost to a beneficiary who enrolled in a private plan. (A beneficiary making the change could switch back to Medicare during an annual open enrollment period.) Both HMOs and conventional insurers would be eligible to participate in this "voucher" system and to qualify, a plan would have to offer benefits at least as comprehensive as Medicare Parts A and B benefits. (Plans would be free to offer added benefits to attract enrollees.)

Clinical trials begin on new substance which mimics blood functions

The first commercially produced example of artificial blood is now being readied for shipment to a network of medical centers for clinical trials.

According to a recent issue of the *Journal of the American Medical Association*, Fluosol, as the substance is known, will be used for those patients who, because of religious beliefs, would otherwise refuse blood transfusions.

Fluosol acts in the body as a medium for the transportation of oxygen, the same job that hemoglobin performs in real blood. However, its effect lasts only about 72 hours and it lacks clotting factors and other properties of the real thing.

In other words, doctors assure, oxygen transporters such as Fluosol are not envisioned as a treatment of choice when blood is available.

If it's not your conversation . . . it could be hypersomnia . . .

Insomnia is not the only problem being reported at sleep disorder centers anymore. Hypersomnia, the problem of falling asleep at inconvenient times, is being reported by slightly over 50% of the 4,000 patients who have sought help from physicians at sleep disorder centers over the past two years.

A study reported in a recent issue of the *Journal of the American Medical Association*, says the condition is characterized by falling asleep in situations such as conversations, during meals, watching an exciting television show, and so forth.

Within this category falls the problem of narcolepsy which is marked by sudden, brief periods of sleep which strike repeatedly at any time during day or night — often with muscular weakness during the attacks.

Although hypersomnia accounted for 50% of the 3,900 diagnoses made, it is actually believed to affect only 3% to 4% of the general population. Insomnia, on the other hand, which was the second most frequently diagnosed condition at the sleep centers, is still believed to affect a larger segment of the population — somewhere between 14% and 35%.

Pneumococcal vaccine not for routine use

Although pneumococcal vaccine has proven effective in certain groups likely to develop pneumococcal pneumonia, the American College of Physicians (ACP) cautions against universal use of the vaccine in healthy persons — especially those over 65.

Despite the fact that Medicare covers the cost of the relatively safe and effective vaccine, the ACP maintains that current data on healthy, elderly persons' sickness and death rates from pneumococcal pneumonia cannot support routine vaccination of all these persons. Physicians should evaluate the vaccine's potential benefit to each individual before routinely administering the drug.

Dramatized diseases lead to headaches of their own

Broadway has discovered disease, a phenomenon replete with potential problems for physicians, according to a recent issue of *American Medical News*.

In recent years, theatergoers have been exposed to the problems caused by deafness, quadriplegia and neurofibromatosis in the plays "Children of a Lesser God," "Whose Life Is It, Anyway" and "The Elephant Man." Now, a regional theater in Chicago has produced a play with Broadway ambitions called "Standing On My Knees," which concerns the anguish caused by schizophrenia.

But for physicians, this sudden trend toward "dramatized disease" raises the specter of misleading information about disease and those who treat it.

For example, according to Herbert Meltzer, M.D., professor of psychiatry at the University of Chicago, "Standing On My Knees" is not a typical portrait of schizophrenia, nor does it accurately depict the role of the psychiatrist.

"There are a number of problems with the therapist," he says. "Some are technical, such as the therapist's combination of megavitamins and chlorpromazine (an antipsychotic agent) since the two represent opposing philosophies of treatment.

"More importantly, the therapist says things to the patient that most therapists would never say, such as 'You are not normal, and never will be normal.' In the context of the play, that came across almost as an assault. The therapist also suggested that schizophrenics are people who feel more, see more, and are more sensitive. In fact, with most schizophrenics, there is a diminution of perception. They are generally less responsive."

Dr. Meltzer does feel, however, that "Standing On My Knees" gives an accurate portrayal of a type of the disease that is marked by relapses and remissions — and it does convey some of the heretofore undisclosed feelings which accompany a loss of competence.

New devices aid scoliosis patients

Until recently, a child with scoliosis faced either years of treatment with a brace or major corrective surgery. Now two orthopedic research teams have limited the progression of the scoliosis, (and sometimes actually reduced curvatures) by using electrical devices to stimulate muscle contraction.

According to a report in a recent issue of the *Journal of the American Medical Association*, Walter P. Bobeckho, M.D., chief of orthopedic surgery at the Hospital for Sick Children in Toronto, and his colleagues, implant a small receiver into the backs of their young patients, connecting wires to muscles on the convex part of the curve. A bedside radio transmitter activates the device,

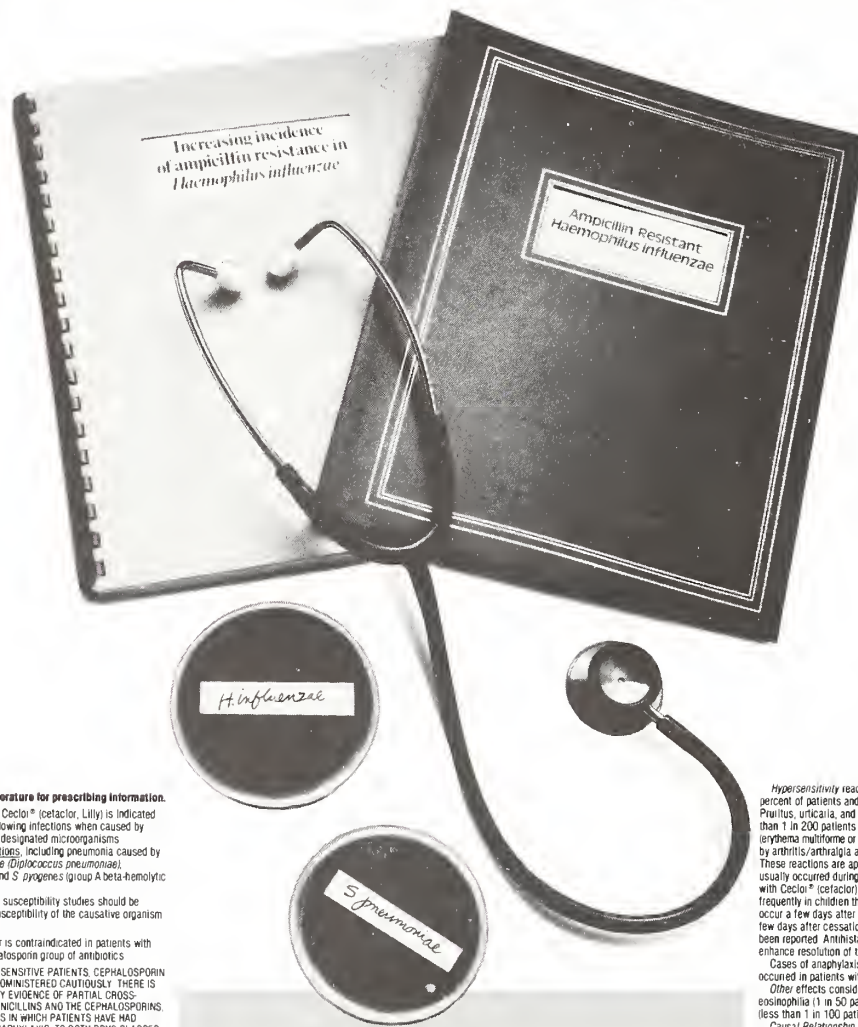
and treatment occurs only when the child is asleep.

In their eight-year experience with internal stimulation, they have achieved success in arresting scoliosis in 117 of 141 children.

A research team at Rancho Los Amigos Rehabilitation Engineering Center in Downey, Ca., led by orthopedist John C. Brown, M.D., favors external stimulation to achieve similar results.

In this technique, a portable battery-operated stimulator sends electrical impulses through wires to disks placed over the convex side of the spinal curve. It is attached before the child goes to sleep and is removed on waking.

An added complication... in the treatment of bacterial bronchitis*



Brief Summary

Consult the package literature for prescribing information.

Indications and Usage: Cefaclor (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections: including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefaclor.

Contraindication: Cefaclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cefaclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antioglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefaclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefaclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no teratogenic or antenatal effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in fetuses given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Cefaclor.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefaclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefaclor.⁷

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cefaclor

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Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis, arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefaclor (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy. Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[100281R]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefaclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

200066



The new troubleshooters

Before, there were headaches, ill will and miles of red tape. Now, along comes the OSMA with a company that hopes to change all that

Rebecca J. Doll

Editor's Note: On February 15, the OSMA launched an affiliate corporation called Physicians Administrative Corporation of Ohio (PACO). PACO is designed to provide Ohio physicians with a variety of practice management services and products at competitive rates. Several projects are scheduled to begin soon. One such project, direct entry billing (tape to tape) for Medicaid, has already begun and is being offered to physicians throughout the state. The Journal spoke with PACO Board Chairman Herman I. Abromowitz, M.D., Dayton, about the Corporation.

THE OSMA JOURNAL: What exactly is PACO's purpose?

Herman I. Abromowitz, M.D.: For many years, the OSMA has offered

various programs, services and consultation to physicians about the business aspects of their practices. In recent years, we have seen an increase in the number of requests for this type of assistance and for the past year, a dramatic increase in requests. We felt it was time to formalize these activities and become more responsive in this area.

JOURNAL: What do you feel accounts for this dramatic increase?

Dr. Abromowitz: For one thing, we are seeing fewer solo practices and an increase in the number of group practices. Group practice often involves more business detail. This is an area in which many physicians feel uncomfortable and thus they seek out

help. At the same time, third-party payment programs have become increasingly complex. It is not unusual for the OSMA, through its Ombudsman Program, to receive 20 to 30 calls per week for help with third-party problems.

JOURNAL: What types of services will be available?

Dr. Abromowitz: We envision various programs which will assist the physician to streamline his or her business practice and thus improve his or her entire medical practice. These services might include assistance with billing procedures, tips on cutting office overhead, practice management seminars for physicians and office personnel, patient health education

materials and so forth. Currently we are offering a program which will assist physicians in improving their billing procedures with the Medicaid program.

JOURNAL: Can you explain that program?

Dr. Abromowitz: The program is a system called Direct Entry (tape to tape) billing. Direct entry of an insurance claim form is the most efficient method of filing a claim with a carrier because it eliminates several levels of paper handling. Under the Medicaid program, those providers who utilize direct entry billing are reimbursed on the average of within 21 days after receipt. This compares with about three to four months turnaround time when the provider uses a paper claim.

JOURNAL: Exactly how does direct entry work?

Dr. Abromowitz: When a physician contracts with PACO for this service, he sends the data to PACO, usually on the Medicaid claim form. No special form is needed and corrections may be made on the form.

JOURNAL: Is that important?

Dr. Abromowitz: It's very important in terms of saving claim preparation time. Paper claims which are sent by the physician directly to the Welfare Department must be "clean" in that they must be free of errors, corrections and be perfectly typed. With our program, corrections on the claim are not a problem. Upon receipt of the claim PACO will key punch the data, verify it and place it on a magnetic computer tape that is compatible with the Ohio Department of Public Welfare's computer system. The tape is then delivered to ODPW by courier and is processed. In most instances, the physician should receive reimbursement within 21 days.

JOURNAL: What happens if a physician makes a mistake on the claim form?

Dr. Abromowitz: PACO has an extensive editing process which will reject problematic claims. At that point they are reviewed by our data processing personnel who will then contact the physician by telephone to obtain the information necessary to correct the claim. The claim will then be placed on the next tape and sent for processing and payment. This not only saves time but results in quicker

turnaround time for payment. Rarely will a claim be returned to the physician. When the claim is paid, a voucher is sent to the physician so he can reconcile the account. In other words, PACO will follow the claim through the entire process, correcting any errors which might occur along the way and thus save the physician the trouble of refileing claims, dealing with third-party red tape, and of waiting extended periods of time for payment.

JOURNAL: What type of practitioner will benefit most from this service?

Dr. Abromowitz: We feel every physician in Ohio can benefit from this service, whether he has a high or low number of Medicaid patients. Those who currently submit paper claims will benefit tremendously from this type of service. In essence, any physician who is seeking ways in which to reduce his insurance claims paperwork, the number of returned claims and reimbursement turnaround time is going to benefit from this service.

JOURNAL: Will patients benefit in any way from this service?

Dr. Abromowitz: Yes, in several ways. First, it may serve to improve access to medical care for Medicaid patients. One of the primary reasons physicians are reluctant to see Medicaid patients is the amount of paperwork and red tape involved. Since PACO can reduce the paperwork to both the physician and ODPW, we think physicians will be more willing to accept Medicaid patients. Second, by reducing the amount of paperwork and thus handling of a claim, it can be processed at a lower cost per claim. This saves money for both the Welfare Department and the physician and in the long run, the patient.

JOURNAL: What should a physician do if he or she is interested in receiving more information about PACO's services?

Dr. Abromowitz: Physicians should contact PACO President David W. Pennington at 450 W. Wilson Bridge Rd., Worthington, Ohio 43085



Herman I. Abromowitz, M.D., Dayton, is PACO's new Board Chairman.



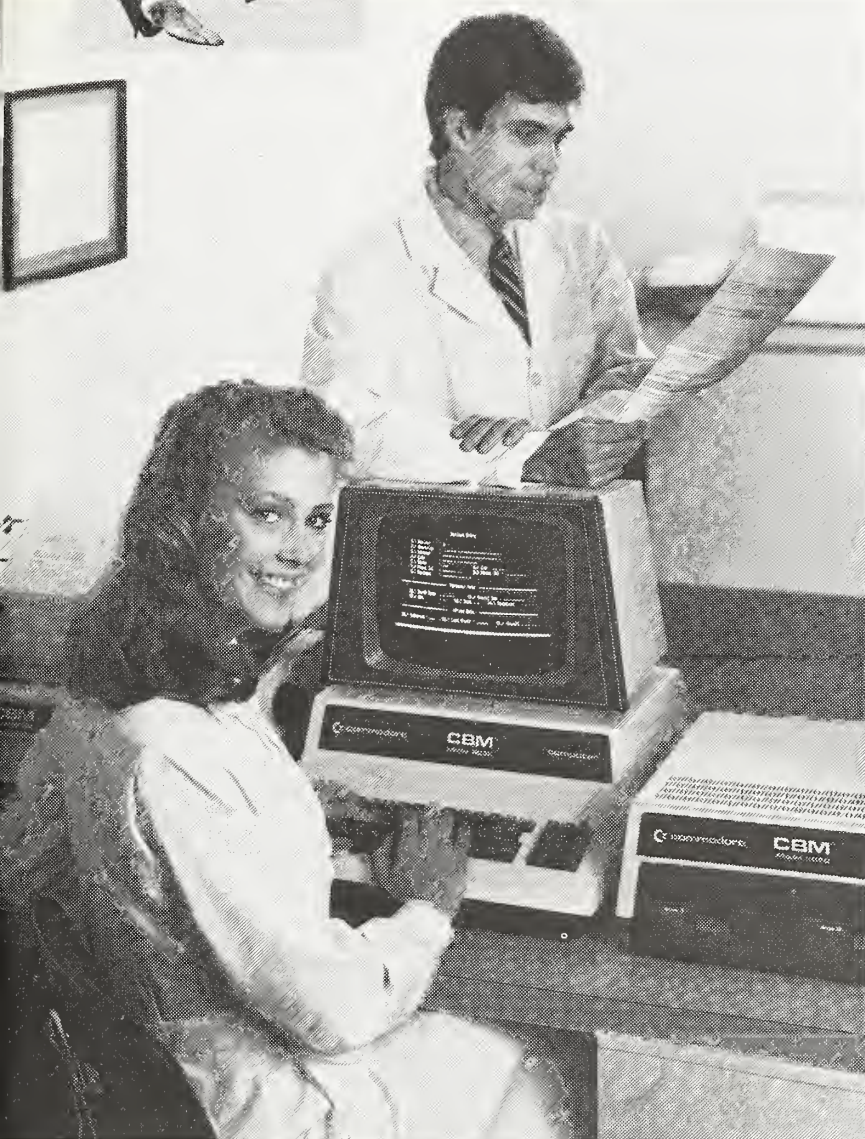
David W. Pennington, formerly OSMA's Director of Government Relations, is PACO's new president.

Rebecca J. Doll is an Associate Executive Director of the OSMA and Director, Department of Communications.



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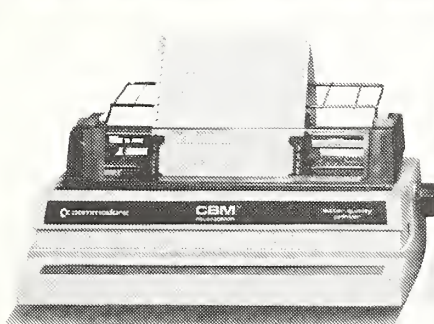
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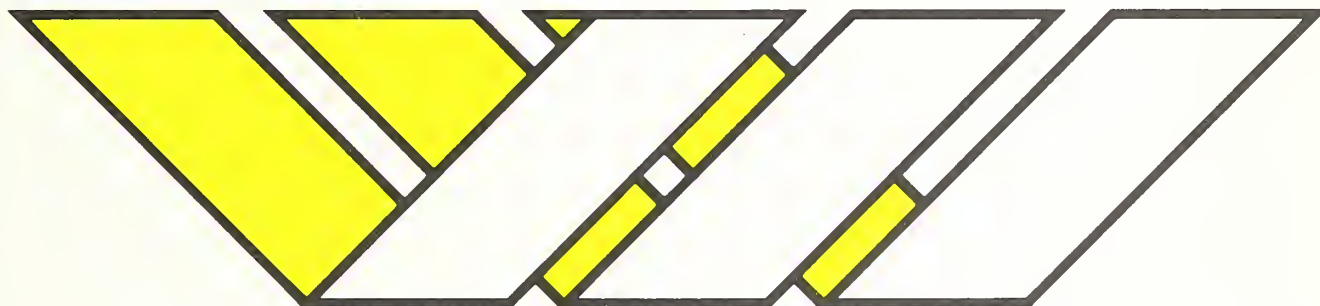


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The 1982 OSMA Annual Meeting

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OSMA ANNUAL MEETING

April 30-May 5 — Dayton



EXPANDING • HORIZONS
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OSMA ANNUAL MEETING April 30-May 5 — Dayton

For OSMA

President-Elect:

ALFORD C. DILLER, M.D., Van Wert family practitioner, has been nominated for the office of President-Elect of the Ohio State Medical Association. His name was placed in nomination by the Van Wert County Medical Society. The Society's President, T.L. Johnson, M.D., wrote the following letter:

Mr. Hart F. Page, Executive Director
Ohio State Medical Association
600 South High Street
Columbus, Ohio 43215

Dear Mr. Page:

By constitutional privilege, the Van Wert County Medical Society is pleased to nominate Alford C. Diller, M.D., Third District Councilor, as a candidate for the office of President-Elect of the Ohio State Medical Association.

Dr. Diller is qualified by membership in good standing of the Van Wert County Medical Society, the Ohio State Medical Association, and the American Medical Association. Dr. Diller has demonstrated his innovative leadership abilities and his dedication to organized medicine by involvement at local, state, and national levels.

It is with pride that we nominate Dr. Diller for the office of President-Elect.

Respectfully,

/s/T.L. Johnson, President
Van Wert County Medical Society

Born in Pandora, Ohio, Alford C. Diller, M.D., received his B.A. from Bluffton College, Bluffton, Ohio, before serving a three-year term with the U.S. Navy's Hospital Corps. After his discharge from the Navy, he entered the University of Chicago School of Medicine, from which he graduated in 1954. Following a rotating internship at Blodgett Memorial Hospital in Grand Rapids, Michigan, and a residency at Parkview Memorial Hospital in Fort Wayne, Indiana, Dr. Diller established a Family Practice in Convoy, Ohio, not far from Van Wert, where he still practices. He was certified by the American Board of Family Practice in 1970, and recertified in 1976.

Dr. Diller has been active, not only in professional organizations, but in a variety of other organizations as well. Besides his work as Third District Councilor to the Ohio State Medical Association (OSMA), and a term as President of the Ohio Academy of Family Physicians, Dr. Diller has also served as coroner for Van Wert County; on the Advisory Board of both the Medical College of Ohio at Toledo and the Kidney Foundation of Northwestern Ohio; and as President of Medical Associates, Inc., the West Central Ohio Health Systems Agency, and the Van Wert Medical Arts Corporation. His widely diversified interests have also led him to positions as the Director of the Van Wert Chamber of Commerce, the Director of the First National Bank in Convoy, and as the founder of CARDS, Inc. (Conventional and Research Data Systems) a computer service bureau based in Lima, Ohio (which he now serves as Chairman of the Board). He also initiated the Van Wert County Hospital Coronary Care Unit, the Van



Alford C. Diller, M.D.
Van Wert

Wert County Mobile Coronary Care Unit and the Tri-County Mental Health Clinic. In 1976, the Van Wert area Jaycees awarded him their "Outstanding Citizen Award." Also during the 1970s, when health planning was a crucial issue, Dr. Diller was an active member of health systems agencies, and last year served as Chairman of the State Health Coordinating Council. Married to the former M. Jane Basinger, The Dillers have four sons, Jonathon, Steven, Philip and Thomas, and a daughter, Leslie Ann.

The Candidates

S. BAIRD PFAHL, Jr., M.D., Sandusky ophthalmologist, has been nominated for the office of President-Elect of the Ohio State Medical Association. His name was placed in nomination by the Erie County Medical Society. The Society's President, Charles J. Everett, M.D., wrote the following letter:

Mr. Hart F. Page
Executive Director
Ohio State Medical Association
600 S. High Street
Columbus, Ohio 43215
Dear Mr. Page:

The Erie County Medical Society is pleased to nominate S. Baird Pfahl, Jr., M.D., Eleventh District Councilor, for the office of President-Elect of the Ohio State Medical Association.

Dr. Pfahl is eminently qualified for this office by virtue of his continued dedication and outstanding contributions to the community, his colleagues in the medical profession and the Ohio State Medical Association.

Dr. Pfahl has served as Secretary of the Erie County Medical Society, President of the Medical Staff of Good Samaritan Hospital and is currently a member of the Board of Trustees of that hospital. He has been an alternate as well as a delegate to the Ohio State Medical Association. For the past 5 1/2 years Dr. Pfahl has been the Eleventh District Councilor. He has also chaired a number of committees on the state level including Cost Effectiveness, State Legislation and currently Chairman of the Auditing and Appropriations Committee of Council as well as the Auxiliary Liaison Committee. He is also a member of the Sports Medicine Committee.

We are therefore proud to nominate Dr. S. Baird Pfahl as candidate for the

office of President-Elect, confident that his knowledge, integrity and skill will enable him to provide outstanding leadership to the Ohio State Medical Association.

Respectfully,
Charles J. Everett, M.D., President
Erie County Medical Society

Following his graduation from high school in Pittsburgh, Pennsylvania, S. Baird Pfahl, M.D., took his undergraduate training at Harvard University, from which he received his B.A. degree in 1955. He went on to receive his medical degree from the University of Pittsburgh in 1959, and following an internship at Western Pennsylvania Hospital and a residency in ophthalmology at Ohio State University, he spent two years at the United States Naval Hospital in Memphis, Tennessee. After his discharge from the Navy, Dr. Pfahl went to Sandusky, Ohio where he established his present practice in ophthalmology.

An active member of professional organizations, Dr. Pfahl has served as Eleventh District Councilor to the Ohio State Medical Association (OSMA) since 1976, and has served as Chairman of the OSMA's Committee on Cost Effectiveness; the Ad Hoc Auxiliary Liaison Committee; and the Auditing and Appropriations Committee. He has also been active in his county medical society and is a member of the American Medical Association.

Dr. Pfahl is also involved in a number of specialty associations. He is a past president of both the Ohio Ophthalmology Society and the Ophthalmology Society of Northwest Ohio; is a diplomate of the American Board of Ophthalmology; and a Fellow



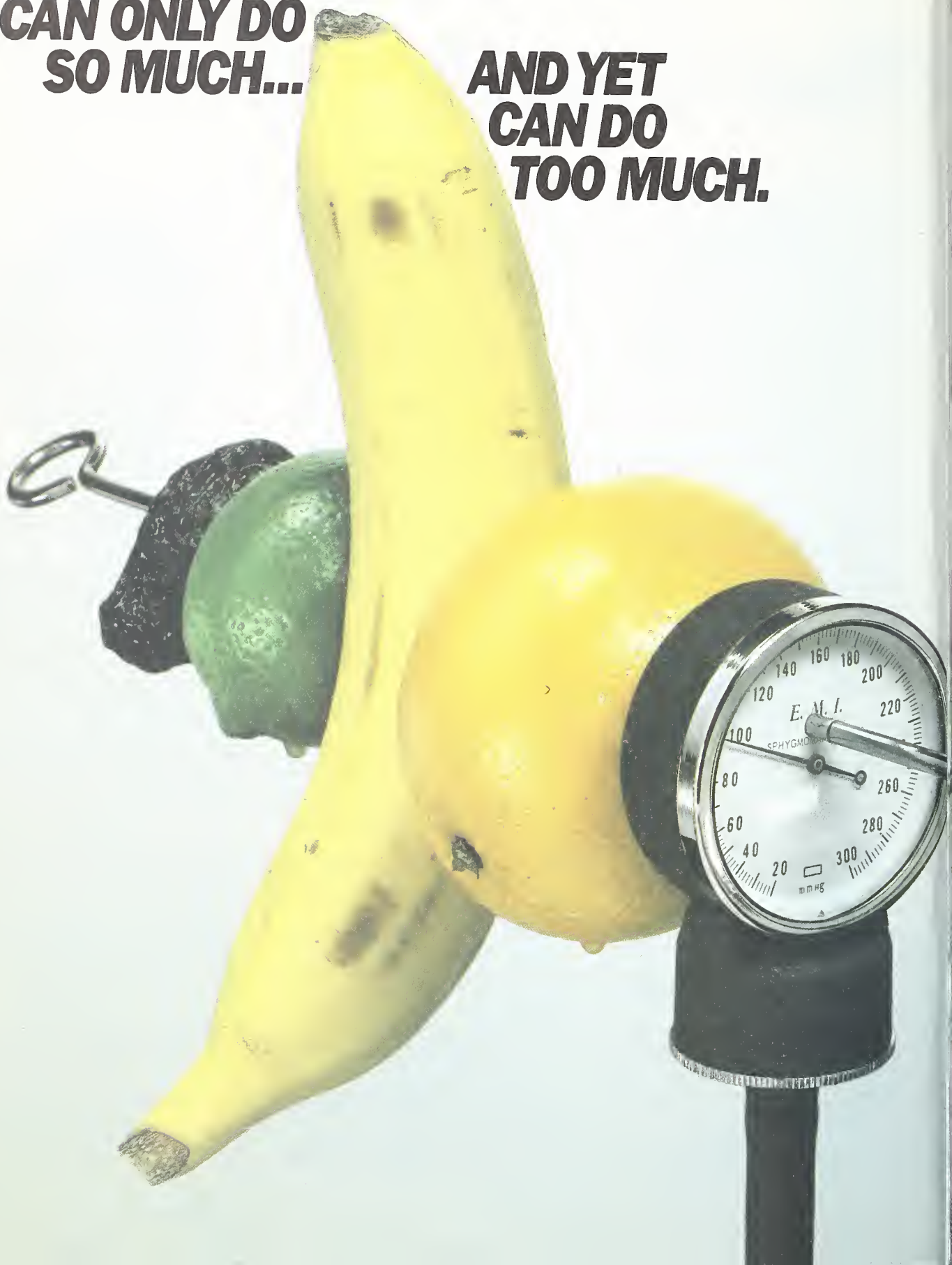
S. Baird Pfahl, Jr., M.D.
Sandusky

of the American Academy of Ophthalmology. He also maintains an active membership in the Society for Contemporary Ophthalmology, the American Intraocular Implant Society and the Contact Lens Association of Ophthalmologists. Along other professional lines, Dr. Pfahl is a team physician for Huron City Schools, and has recently received an appointment to the Medical College of Ohio, where he serves as Clinical Assistant Professor in the Department of Surgery.

Outside his profession, Dr. Pfahl is an active member in the Rotary Club of Sandusky, having served a year as the group's President. Married to the former Phyllis Bolman, the Pfahls have four sons, Scott, Doug, Dan and Todd.

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Please see Brief Summary of Prescribing Information on following page.

BRIEF SUMMARY
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Hydrochlorothiazide	25 mg

WARNING: This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

DESCRIPTION: IINDERIDE combines two antihypertensive agents. IINDERAL (propranolol hydrochloride), a beta-adrenergic blocking agent, and hydrochlorothiazide, a thiazide diuretic-antihypertensive.

INDICATION: IINDERIDE is indicated in the management of hypertension. (See boxed warning.)

CONTRAINDICATIONS: Propranolol hydrochloride (INDERAL®): Propranolol hydrochloride is contraindicated in 1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS: Propranolol hydrochloride (INDERAL®): CARDIAC FAILURE: Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn, b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOLYCEMIA: Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

USE IN PREGNANCY: Propranolol hydrochloride (INDERAL®): The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

Hydrochlorothiazide: Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers: Thiazides appear in breast milk. If the use of the drug is deemed essential, the patient should stop nursing.

PRECAUTIONS: Propranolol hydrochloride (INDERAL®): Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncope attacks, or orthostatic hypotension.

As with any new drug over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause are: dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements such as foods with a high potassium content.

Any chloride deficit is generally mild, and usually does not require specific treatment except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

ADVERSE REACTIONS: Propranolol hydrochloride (INDERAL®): Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Miscellaneous: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

Hydrochlorothiazide: **Gastrointestinal:** anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

Central Nervous System: dizziness, vertigo, paresthesias, headache, xanthopsia.

Hematologic: leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular: orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: purpura, photosensitivity, rash, urticaria, necrotizing angitis (vasculitis, cutaneous vasculitis), fever, respiratory distress including pneumonitis, anaphylactic reactions.

Other: hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

DOSAGE AND ADMINISTRATION: The dosage must be determined by individual titration (see boxed warning).

Hydrochlorothiazide is usually given at a dose of 50 to 100 mg per day. The initial dose of propranolol is 40 mg twice daily and it may be increased gradually until optimum blood pressure control is achieved. The usual effective dose is 160 to 480 mg per day.

One to two IINDERIDE tablets twice daily can be used to administer up to 320 mg of propranolol and 100 mg of hydrochlorothiazide. For doses of propranolol greater than 320 mg, the combination products are not appropriate because their use would lead to an excessive dose of the thiazide component.

When necessary, another antihypertensive agent may be added gradually beginning with 50 percent of the usual recommended starting dose to avoid an excessive fall in blood pressure.

OVERDOSEAGE OR EXAGGERATED RESPONSE: The propranolol hydrochloride (INDERAL®) component may cause bradycardia, cardiac failure, hypotension, or bronchospasm.

The hydrochlorothiazide component can be expected to cause diuresis. Lethargy of varying degree may appear and may progress to coma within a few hours, with minimal depression of respiration and cardiovascular function, and in the absence of significant serum electrolyte changes or dehydration. The mechanism of central nervous system depression with thiazide overdosage is unknown. Gastrointestinal irritation and hypermotility can occur, temporary elevation of BUN has been reported, and serum electrolyte changes could occur, especially in patients with impairment of renal function.

TREATMENT: The following measures should be employed. **GENERAL:**—If ingestion is, or may have been, recent, evacuate gastric contents taking care to prevent pulmonary aspiration. **BRADYCARDIA:**—Administer atropine (0.25 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously. **CARDIAC FAILURE:**—Digitalization and diuretics. **HYPOTENSION:**—Vasopressors, e.g., levaterenol or epinephrine. **BRONCHOSPASM:**—Administer isoproterenol and aminophylline. **STUPOR OR COMA:**—Administer supportive therapy as clinically warranted. **GASTROINTESTINAL EFFECTS:**—Though usually of short duration, these may require symptomatic treatment. **ABNORMALITIES IN BUN AND/OR SERUM ELECTROLYTES:**—Monitor serum electrolyte levels and renal function; institute supportive measures as required individually to maintain hydration, electrolyte balance, respiration, and cardiovascular-renal function.

HOW SUPPLIED: No. 474—Each IINDERIDE®-40/25 tablet contains 40 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 476—Each IINDERIDE®-80/25 tablet contains 80 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100.

References: 1. Veterans Administration Cooperative Study Group on Antihypertensive Agents. J. A. M. A. 237:2303 (May 23) 1977. 2. Bravo, E. L., Tarazi, R. C., and Dustan, H. P. N. Engl. J. Med. 292:66 (Jan. 9) 1975. 3. Holliteld, J. W., and Slaton, P. C.: Acta Med. Scand. [Suppl.] 647:67, 1981. 4. Holland, O. B., Nixon, J. V., and Kuhnert, L. Am. J. Med. 70:762 (Apr.) 1981.

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Dayton, Ohio April 30-May 5

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(Name of Hotel)

(Address) Dayton, Ohio

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Price Range _____ Guaranteed _____

No. of Persons _____ Arrival Date _____ Hour of Arrival _____ Departure Date _____

Name _____

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ANNUAL MEETING FORMAT

April 30 — May 5, 1982, DAYTON

Headquarters Hotel — Stouffer's Dayton Plaza Hotel, 5th & Jefferson Streets
Coheadquarters Hotel — Sheraton Dayton Downtown, 21 S. Jefferson Street
Auxiliary to OSMA Headquarters Hotel — Daytonian, Ludlow at Third Street
Resource Center — Dayton Convention Center, 22 Dave Hall Plaza
Art and Photographic Exhibit — Stouffer's Dayton Plaza Hotel

Friday, April 30

OSMA Council	8:30 - 11:30 AM
Breakfast/Meeting — Van Cleve II, ST	
Pediatrics	9 AM - 12 NOON
Meeting — Van Cleve IV, ST	
Emergency Resolution Committee	12 NOON
Luncheon/Meeting — Van Cleve III, ST	
OMPAC Board	12 Noon - 2 PM
Luncheon — Plaza XIV	
OSMA Delegation to AMA	2 - 4 PM
Meeting — Van Cleve III, ST	
District Caucus	4 - 5:30 PM
Meetings	
District 1, Room 302, CC	District 6, Room 207, CC
District 2, Room 203, CC	District 7, Room 307, CC
District 3, Room 306, CC	District 8, Room 308, CC
District 4, Room 204, CC	District 9, Room 309, CC
District 5, Room 303, CC	District 10, Room 202, CC
Medical Student Section, Room 208, CC	
District 11, Room 205, CC	
District 12, Room 206, CC	
House of Delegates	
Registration	3 - 5:30 PM
Outside Assembly Hall, CC	
Sit-down dinner	5:30 PM
Van Cleve I & II, ST	
Opening Session	7 - 9 PM
Assembly Hall, CC	

Following House of Delegates

Montgomery County Medical Society Glee Club
 Theater, CC

After the Glee Club

Reception — sponsored by Montgomery County Medical Society
 and all other county societies comprising District 2
 Room 302, CC

Saturday, May 1

Reference Committees	
Breakfast	6:30 - 7:30 AM
Van Cleve I & II, ST	
Hearings	7:30 - 11:30 AM
Committee No. 1, Room 302, CC	
Committee No. 2, Room 303, CC	
Committee No. 3 & President's Address, Rooms 304 & 305, CC	
Nominations, Room 306, CC	
into Executive Session	1:30 PM
Same rooms used earlier	
Drafts & Reports	9 PM
Prepared and Reviewed by Committees	
Same rooms used earlier	
OMPAC	
Social Hour & Luncheon	11:30 AM - 1:30 PM
Van Cleve, ST	
PICO	1:30 - 2:30 PM
Update Meeting — Room 203, CC	
Medical Mutual	4:30 - 6:30 PM
Reception — Van Cleve II, ST	
OMIM	5 - 6:30 PM
Reception — Van Cleve I, ST	

Sunday, May 2

District Caucus	9 AM
Meetings (reports ready)	
District 1, Room 302, CC	District 7, Room 307, CC
District 2, Room 203, CC	District 8, Room 308, CC
District 3, Room 306, CC	District 9, Room 309, CC
District 4, Room 204, CC	District 10, Room 202, CC
District 5, Room 303, CC	District 11, Room 205, CC
District 6, Room 207, CC	District 12, Room 206, CC
Medical Student Section, Room 208, CC	

Physical Medicine & Rehabilitation

Luncheon	12 NOON
Van Cleve IV, ST	
Meeting	2 - 5 PM
Room 207, CC	

Psychiatry

Breakfast/OPA Council & Research & Education Foundation Meeting	8 - 11:30 AM
Roof Top, SH	
Luncheon	12 NOON
Glenn Room, SH	
Meeting	1 - 5 PM
Wright Brothers, SH	

House of Delegates

Registration	11:30 AM - 1 PM
Outside Assembly Hall	
Final Session	1 PM
Assembly Hall, CC	
Sit-down Dinner	6 PM
Van Cleve I & II, ST	
Resume Final Session	6:45 - 8 PM
Assembly Hall, CC	

Internal Medicine

Meeting	1 - 5 PM
Room 204, CC	

Anesthesiology

Meeting	1:30 - 4:30 PM
Room 202, CC	

Ophthalmology

Scientific Session	2 - 5 PM
The Theatre, CC	
Dinner	5 - 9 PM
Regency Ballroom, SH	

Monday, May 3**Ophthalmology**

Business Meeting	8 - 10 AM
The Theatre, CC	
Board Meeting/Breakfast	8 - 10 AM
Van Cleve IV, ST	
Business Meeting	10 - 11:30 AM
The Theatre, CC	
Luncheon/cocktails	11:30 AM - 1:30 PM
Regency Ballroom, SH	
Scientific Session	1:30 - 5 PM
The Theatre, CC	

OSMA Council

Meeting/Breakfast	8:30 AM
Van Cleve III, ST	

Pfizer Dialogue

Room 203, CC	9 AM - 4 PM
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Ohio Committee on Trauma, A.C.S.

Scientific Session	9 AM - 12 NOON
Room 207, CC	

Sports Medicine

Meeting	9 AM - 12 NOON
Room 303, CC	
Luncheon	12 NOON
Van Cleve I & II, ST	
Meeting	1 - 4 PM
Room 303, CC	

Wright State Day

Rooms 304 & 305, CC	9 AM - 4 PM
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PICO

Shareholders Meeting	10 AM
Room 204, CC	

Rheumatology

Luncheon	12 NOON - 1:15 PM
Van Cleve III, ST	
Meeting	1:30 - 5 PM
Room 204, CC	

Emergency Medicine

Meeting	1 - 5 PM
Room 207, CC	

Pathology

Board of Governors Meeting	4:30 - 6 PM
Room 306, CC	

Neurosurgical

Dinner	7 PM
Dayton Racquet Club	

Tuesday, May 4**Neurosurgery**

Breakfast	7 - 8:30 AM
Van Cleve III, ST	
Meeting	8:30 AM - 12 NOON
Rooms 304-305, CC	
Luncheon	12 NOON
Van Cleve III, ST	
Meeting	1:30 - 5 PM
Rooms 304-305, CC	

Pathology

Meeting	9 AM - 4:30 PM
Room 302, CC	

Colon and Rectal Surgery

Luncheon	11:30 AM - 1 PM
Van Cleve IV, ST	
Meeting	1 - 5 PM
Room 203, CC	

Family Practice

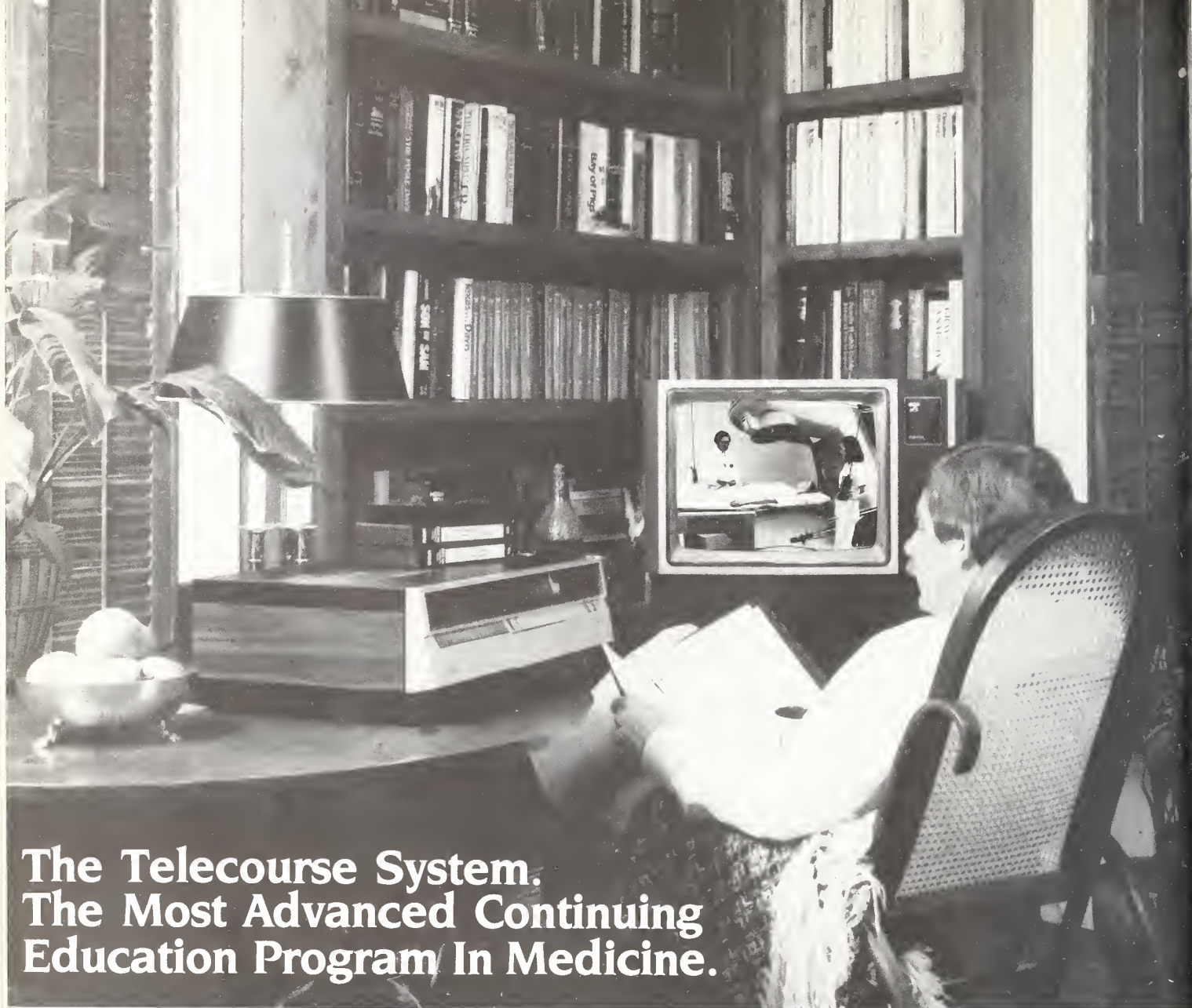
Meeting	2 - 5 PM
Room 202, CC	

Wednesday, May 5**Plastic Surgeons**

Meeting	9 AM - 12 NOON
Van Cleve I, ST	
Luncheon	12 NOON
Racquet Club	

Allergy & Immunology

Meeting	8:30 AM - 12 NOON
Van Cleve II, ST	
Luncheon	12:30 PM
Daytonian	



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EXPANDING HORIZONS
THE WRIGHT WAY IN '82
OSMA ANNUAL MEETING April 30-May 5 — Dayton

MEETING ROOM LOCATIONS

In Stouffer's Dayton Plaza

Ballroom Level:

Dayton Room
Van Cleve I
Van Cleve II
Van Cleve III
Van Cleve IV

14th Floor:

Plaza XIV

In Sheraton Dayton Downtown

Second Floor:

Regency Ballroom

Third Floor:

Glenn Room

Rogers Room
Wright Brothers Room
Earhart Room
Lindbergh Room
Rickenbacker Room

In Dayton Convention Center

Main Lobby, First Floor:

OSMA Office
Assembly Hall

Second Floor:

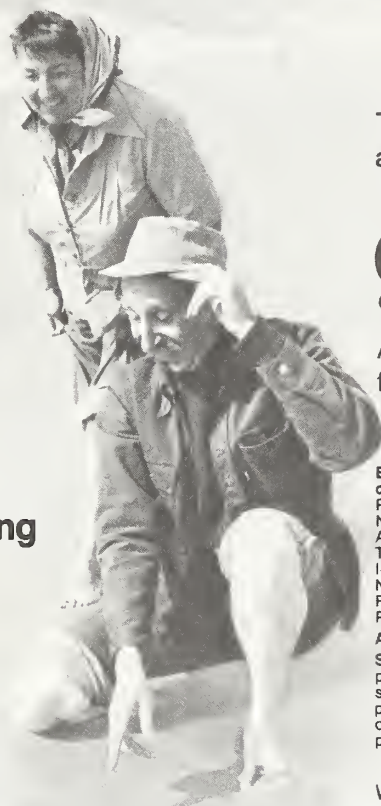
Room 201
Room 202
Room 203
Room 204
Room 205

Room 206
Room 207
Room 208
Room 209

Third Floor:

Room 301 (VIP Lounge)
Room 302
Room 303
Room 304
Room 305
Room 306
Room 307
Room 308
Room 309
Room 310
Room 311
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SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

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INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

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Comparison of Anorectics

	Agent	Amine Classification	Half-life ^a	Variety of Dosage Form	Degree of CNS Effects
Low Abuse Potential	Diethylpropion	Tertiary	4-6 hrs.	25 mg tablet, 75 mg controlled-release tablet	Mild euphoria, mild stimulation
	Mazindol	Nonphenylethyl-amine	33-55 hrs.	1 & 2 mg tablet	Mild euphoria, mild stimulation
	Fenfluramine	Secondary	10-30 hrs.	20 mg tablet	Moderate sedation (mild to moderate depression, a side effect, is also sometimes designated as a CNS effect)
	Phentermine	Primary	19-24 hrs.	8 & 37.5 mg tablet, 8, 15 & 30 mg capsule 15 & 30 mg capsule (resin complex) 15 & 30 mg timed release capsule	Mild euphoria, moderate stimulation
High Abuse Potential	Phenmetrazine	Secondary	7-9 hrs.	25 mg tablet, 50 & 75 mg prolonged action tablet	Marked euphoria, marked stimulation
	Amphetamine	Primary	10-30 hrs.	Various	Marked euphoria, marked stimulation

^aDelayed release characteristics of certain dosage forms must also be taken into account.

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Tenuate Dospan®^{IV}

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controlled-release

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Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly. When central nervous system active agents are used, consideration must always be given to the possibility of adverse interactions with alcohol. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychological dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression, changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: Cardiovascular: Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. Central Nervous System: Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. Gastrointestinal: Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. Allergic: Urticaria, rash, ecchymosis, erythema. Endocrine: Impotence, changes in libido, gynecomastia, menstrual upset. Hematopoietic System: Bone marrow depression, agranulocytosis, leukopenia. Miscellaneous: A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride) One 25 mg tablet three times daily, one hour before meals, and in the evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg tablet daily, swallowed whole, in the morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of June, 1980

Reference: 1. Abramson R, Garg M, Cioffari A, and Rotman PA, An Evaluation of Behavioral Techniques Reinforced with an Anorectic Drug in a Double-Blind Weight Loss Study. J Clin Psych 41:234-237, 1980.

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OSMA ANNUAL MEETING April 30-May 5 — Dayton

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CME Hours:
3 Category I

Date:
Wednesday, May 5

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Time:
8:40 AM to 12:30 PM

Sponsor:
OSMA Section on Allergy and
Immunology and Ohio Society of
Allergy and Immunology

Schedule:
8:40 - 8:45 AM
General Introduction
— *Robert A. Bernstein, M.D.*
Dayton

8:45 - 9:30 AM
New Applications in the
Treatment of Rhinitis and
Asthma
— *Richard A. Krumholz, M.D.*
Director, The Institute of
Respiratory Diseases
Kettering Medical Center
Kettering

9:30 - 9:45 AM

IgE, Fifteen Years Later
— *Robert A. Bernstein, M.D.*

9:45 - 10:15 AM
The Predictive Value of PRIST
AND RAST in Allergy Diagnosis
— *Clement A. Maccia, M.D.*
Asst. Clinical Professor of
Pediatrics
Division of Allergy and
Immunology
Rutgers Medical School
New Brunswick, New Jersey

10:15 - 10:45 AM
Coffee Break

10:45 - 11:30 AM
Clinical Application of In-Vitro
Allergy Tests (RAST)
— *William T. Kniker, M.D.*
Professor, Pediatrics and
Microbiology
University of Texas
Southwestern Medical School
and Director, Clinical
Immunology
Health Sciences Center
San Antonio, Texas

11:30 - 12 Noon
Questions, Answers, and
Discussion
— *Drs. Krumholz, Maccia, Kniker
and Bernstein*

12:30 PM
Business Meeting and Luncheon
for Membership
The Daytonian

ANESTHESIOLOGY

CME Hours:
3 Category I

Date:
Sunday, May 2

Place:
Room 202, Dayton Convention
Center

Time:
1:30 to 4:30 PM

Sponsor:
OSMA Section on Anesthesiology
and Ohio Society of
Anesthesiology

Schedule:
1:30 - 2:15 PM
Dorsal Penile Block
Caudal Blocks in Children (two

presentations)
— *Haig Tozbikian, M.D.*
Department of Anesthesia
Kettering Medical Center
Kettering

2:15 - 3:00 PM
Current Status of Epidural
Blocks in Obstetrics
— *R. Bryan Roberts, M.D.*
Miami Valley Hospital
Dayton

3:00 - 3:45
The Anesthesiologist as a
Consultant
— *Keith Callender, M.D.*
Department of Anesthesia
Kettering Medical Center
Kettering

3:45 - 4:30
Question and Answer Period

EMERGENCY MEDICINE

CME Hours:

3 Category I

Date:

Monday, May 3

Place:

Room 207, Dayton Convention Center

Time:

1:00 to 5:00 PM

Sponsor:

Ohio Chapter, American College of Emergency Physicians

Schedule:

1:00 - 1:05 PM

Introduction

— *Mark L. DeBard, M.D.*

Course Director and Presiding Officer

St. Elizabeth Medical Center
Dayton

1:05 - 2:30 PM

Brain Resuscitation

— *Glenn C. Hamilton, M.D.*

Chairman, Dept. of Emergency Medicine

Wright State University School of Medicine
Dayton

2:30 - 3:00 PM

Resource Center Tour

3:00 - 4:00 PM

Dizziness and Syncope

— *Norman Schneiderman, M.D.*

Director, Emergency Department
Miami Valley Hospital
Dayton

4:00 - 5:00 PM

Mark L. DeBard, M.D.

Associate Director, Emergency Department
St. Elizabeth Medical Center
Dayton

5:00 PM

Adjournment

FAMILY PRACTICE

CME Hours:

3 Category I

Date:

Tuesday, May 4

Place:

Room 202, Dayton Convention Center

Time:

2:00 to 5:00 PM

Sponsor:

OSMA Section on Family Practice and Ohio Academy of Family Physicians

Speaker:

John A. Lombardo, M.D., Medical Director
Department of Orthopaedic Surgery
Cleveland Clinic Foundation
Cleveland

Topic:

Low Back, Pelvis, Thigh and Knee Problems in the Athletic Family

OPHTHALMOLOGY

CME Hours:

10 Category I

Date:

Sunday, May 2 and Monday, May 3

Place:

The Theatre, Dayton Convention Center

Time:

1:30 - 5:30 PM (Sunday)

8:30 - 11:30 AM (Monday)

1:30 - 5:30 PM (Monday)

Sponsor:

OSMA Section on Ophthalmology and the Ohio Ophthalmological Society

Topic:

Iatrogenic Disease in Ophthalmology

Schedule:

Sunday, May 2

1:30 - 1:40 PM

Welcome and Introduction

— *John D. Bullock, M.D.*,

F.A.C.S.

Associate Clinical Professor
Department of Ophthalmology
Wright State University
Dayton

1:40 - 2:00 PM

Therapeutic Indications and Contraindications

— *William H. Havener, M.D.*

Professor and Chairman
Department of Ophthalmology
Ohio State University
Columbus

Session 1 Moderator:

— *William H. Havener, M.D.*

2:00 - 2:15 PM

Systemic and Local Toxicity from

Topical Ophthalmic Medications

— *Jonathan H. Lass, M.D.*

Case Western Reserve University
University Hospitals
Cleveland

2:15 - 2:25 PM

Complications of Eyelid

Cryotherapy

— *Robert B. O'Dair, M.D.*

Ohio State University
Columbus

2:25 - 2:40 PM

Complications of Eyelid Surgery

— *Dwight R. Kulwin, M.D.*

Assistant Professor of Ophthalmology
University of Cincinnati College of Medicine
Cincinnati

2:40 - 2:50 PM

Diagnosis and Management of Complications of Ptosis Surgery

— *John A. Burns, M.D.*

Clinical Associate Professor of Ophthalmology
Director of the Ophthalmic Plastic Surgery Section
Ohio State University
Columbus

2:50 - 3:00 PM

Stevens-Johnson Syndrome

— *William J. Reinhart, M.D.*

Case-Western Reserve University
Cleveland

3:00 - 3:10 PM

Hazards of Radial Keratotomy

— *Richard H. Keates, M.D.*

Professor of Ophthalmology
Ohio State University
Columbus

3:10 - 3:20 PM

Corneal Infections Induced by Contact Lenses

(continued)

Naturally smooth...



Naturally smooth Zaroxolyn®





Smoothly controls hypertension with once-daily dosage

Zaroxolyn[®]
metolazone/Pennwalt

Zaroxolyn[®]

metolazone/Pennwalt
2½, 5, and 10 mg tablets

Smooth step-1 diuretic

24-hour duration of action is smooth and sustained; fits naturally into a 24-hour day

24-hour duration of action permits convenient, effective, once-daily dosage

Once-a-day dosage enhances patient compliance

Step-1 antihypertensive effectiveness is unsurpassed¹⁻⁵

Positive side effect profile^{1,6}

*Long-term efficacy with Zaroxolyn alone^{1,6,7}
can spare patients the cost and side effects encountered with step-2 antihypertensives*

Zaroxolyn costs less than most other diuretics and diuretic combinations⁸

Before prescribing, see complete prescribing information in the package insert, or in PDR, or available from your Pennwalt representative. The following is a brief summary. **Indications:** Zaroxolyn (metolazone) is an antihypertensive diuretic indicated for the management of mild to moderate essential hypertension as sole therapeutic agent and in the more severe forms of hypertension in conjunction with other antihypertensive agents, and also, edema associated with heart failure and renal disease. Routine use in pregnancy is inappropriate. **Contraindications:** Anuria, hepatic coma or precoma; allergy or hypersensitivity to Zaroxolyn. **Warnings:** In theory cross-allergy may occur in patients allergic to sulfonamide-derived drugs, thiazides or quinethazone. Hypokalemia may occur, and is a particular hazard in digitalized patients; dangerous or fatal arrhythmias may occur. Azotemia and hyperuricemia may be noted or precipitated. Considerable potentiation may occur when given concurrently with furosemide. When used concurrently with other antihypertensives, the dosage of the other agents should be reduced. Use with potassium-sparing diuretics may cause potassium retention and hyperkalemia. Administration to women of child-bearing age requires that potential benefits be weighed against possible hazards to the fetus. Zaroxolyn appears in the breast milk. Not for pediatric use. **Precautions:** Perform periodic examination of serum electrolytes, BUN, uric acid, and glucose. Observe patients for signs of fluid or electrolyte imbalance,

namely hyponatremia, hypochloremic alkalosis and hypokalemia. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Insulin requirements may be affected in diabetics. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment is usually necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

References

1. Data on file, Medical Department, Pennwalt Pharmaceutical Division.
2. Sambhi MP, Eggena P, Barrett JD, et al: A cross-over comparison of the effects of metolazone and hydrochlorothiazide therapy on blood pressure and renin angiotensin system in patients with essential hypertension, in Sambhi MP (ed): *Systemic Effects of Antihypertensive Agents*. New York, Stratton Intercontinental, 1976, pp 221-245.
3. Fotiu S, Mroczek WJ, Davidov M, et al: Antihypertensive efficacy of metolazone. *Clin Pharmacol Ther* 16:318-321, 1974.
4. Pilewski RM, Scheib ET, Misage JR, et al: Technique of controlled drug assay in hypertension: V. Comparison of hydrochlorothiazide with a new quinethazone diuretic, metolazone. *Clin Pharmacol Ther* 12:843-848, 1971.
5. Winchester JF, Kellett RJ, Boddy K, et al: Metolazone and bendroflumethiazide in hypertension: Physiologic and metabolic observations. *Clinical Pharmacol Ther* 28:611-618, 1980.
6. Dornfeld L, Kane RE: Metolazone in essential hypertension: The long-term clinical efficacy of a new diuretic. *Current Therapeutic Research* 18:527-533, 1975.
7. Cangiano JL: Effects of prolonged administration of metolazone in the treatment of essential hypertension. *Current Therapeutic Research* 20:745-750, 1976.
8. *Drug Topics Red Book*, 1982.

 DIVISION
PENWALT
ROCHESTER, NEW YORK 14623

Ophthalmology (continued)

— *Richard G. Lembach, M.D.*
Ohio State University
Columbus

3:20 - 3:30 PM
Discussion

3:30 - 4:00 PM
Coffee Break

Session 2 Moderator
— *James E. Bennett, M.D.*
Cleveland

4:00 - 4:10 PM
Pseudomonas Corneal Infections
in Burn Patients
— *William J. Reinhart, M.D.*
Cleveland

4:10 - 4:15 PM
Tetracaine Keratopathy
— *Roger H. S. Langston, M.D.*
The Cleveland Clinic Foundation
Cleveland

4:15 - 4:30 PM
Iatrogenic Bullous Keratopathy
— *Roger H. S. Langston, M.D.*
Cleveland

4:30 - 4:45 PM
Iatrogenic Blood Pressure
Alterations in Glaucoma
— *Paul A. Weber, M.D.*
Ohio State University
Columbus

4:45 - 5:00 PM
Systemic Toxicity from Glaucoma
Therapy
— *Frank J. Weinstock, M.D.*
Clinical Assistant Professor of
Ophthalmology
Ohio State University
Canton

5:00 - 5:10 PM
Iatrogenic Angle Closure
Glaucoma
— *John S. Cohen, M.D.*
University of Cincinnati
Cincinnati

5:10 - 5:20 PM
Steroid Induced Glaucoma
— *Carl F. Asseff, M.D.*
Adjunct Staff and Teaching
Associate
Department of Ophthalmology

Cleveland Clinic Foundation and
First Year Law Student
Cleveland State
University-Marshall College of
Law
Cleveland

5:20 - 5:30 PM
Discussion

6:30 - 8:00
Cocktails & Dinner
Regency Ballroom
Sheraton
Mike Peters
After Dinner Speaker
Pulitzer Prize Winning Political
Cartoonist
Dayton Daily News
Dayton

Monday, May 3
Session 3 Moderator
— *Taylor Ashbury, M.D.*
University of Cincinnati College
of Medicine
Cincinnati

8:30 - 8:40 AM
Complications of Congenital
Cataract Surgery
— *Rees W. Sheppard, M.D.*
University of Cincinnati
Cincinnati

8:40 - 8:55 PM
Post-Operative Endophthalmitis
— *Larry A. Raymond, M.D.*
University of Cincinnati
Cincinnati

8:55 - 9:10 AM
Complications of Vitrectomy
— *Nicholas Zakov, M.D.*
The Cleveland Clinic Foundation
Cleveland

9:10 - 9:25 AM
Complications of Laser Therapy
— *Lawrence J. Singerman, M.D.*
Assistant Clinical Professor of
Ophthalmology
Case Western Reserve University
Cleveland

9:25 - 9:40 AM
Complications of Retinal Surgery
— *Daniel T. Weidenthal, M.D.*
Case Western Reserve University
Cleveland

9:40 - 9:50 AM
Retrolental Fibroplasia

— *Edward W. Purnell, M.D.*
Professor and Chairman
Department of Ophthalmology
Case Western Reserve University
Cleveland

9:50 - 10:00 AM
Discussion

10:00 - 11:30 AM
Business Meeting

11:30 - 1:30 PM
Cocktails and Lunch
Regency Ballroom, Sheraton
Hotel

Session 4 Moderator
— *Froncie Gutman, M.D.*
Chairman, Department of
Ophthalmology
The Cleveland Clinic Foundation
Cleveland

1:30 - 1:40 PM
Post-Operative Sympathetic
Ophthalmia
— *Torrence A. Makley, Jr., M.D.*
Professor of Ophthalmology
Ohio State University
Columbus

1:40 - 1:50 PM
Side Effects of Therapy for
Posterior Uveitis
— *Carol R. Kollarits, M.D.*
Professor and Chairman
Division of Ophthalmology
Medical College of Ohio
Toledo

1:50 - 2:10 PM
Opportunistic Ocular Infections
in the Immuno-Compromised
Patient
— *John D. Bullock, M.D.*
Dayton

2:10 - 2:20 PM
Complications of Enucleation
Surgery
— *Rodney W. McCarthy, M.D.*
Assistant Clinical Professor of
Ophthalmology
Medical College of Ohio
Toledo

2:20 - 2:35 PM
Pathways to Complicating
Strabismus
— *Ronald L. Price, M.D.*
Vice Chairman, Department of

(continued)

Ophthalmology (continued)

Ophthalmology
Head, Section of Pediatric
Ophthalmology and Strabismus
The Cleveland Clinic Foundation
Cleveland

2:35 - 2:45 PM

Drug Induced Optic Neuropathy
— *William E. Cappaert, M.D.*

Case Western Reserve University
Cleveland Metropolitan General
Hospital
Cleveland

2:45 - 3:00 PM

Discussion

3:00 - 3:30 PM

Coffee Break

Session 5 Moderator

— *Bertil F. Larson, M.D.*

Associate Professor and
Chairman

Department of Ophthalmology
Wright State University
Dayton

3:30 - 3:45 PM

Blindness Following

Blepharoplasty

— *Robert R. Waller, M.D.*

Professor and Chairman

Department of Ophthalmology

Mayo Clinic

Rochester, Minnesota

3:45 - 3:55 PM

Orbital Cellulitis Following

Dental Extraction

— *John D. Bullock, M.D.*

Dayton

3:55 - 4:10 PM

Ocular Effects of Radiant Energy
Therapy

— *Abbot G. Spaulding, M.D.*

Clinical Professor of

Ophthalmology

University of Cincinnati

Cincinnati

4:10 - 4:25 PM

Complications of Trans-Antral
Decompression

— *Robert R. Waller, M.D.*

Rochester, Minnesota

4:25 - 4:35 PM

Iatrogenic Horner's Syndrome

— *John Fleishman, M.D.*

Department of Ophthalmology

University of Michigan

Ann Arbor, Michigan

4:35 - 4:50 PM

Neurosurgically Induced Ocular
Disease

— *John M. Tew, M.D.*

Mayfield Neurological Institute
Cincinnati

4:50 - 5:15 PM

Ocular Toxicity of Systemic
Drugs

— *Dennis M. Robertson, M.D.*

Professor of Ophthalmology

Mayo Clinic

Rochester, Minnesota

5:15 - 5:30 PM

Iatrogenic Disease — Ethical and
Legal Considerations

— *Gregory C. Gibson, M.Div.,*

J.D.

Presbyterian Minister

Attorney, Jenks and Myers, Co.,
LPA

Dayton

5:30 - 5:45 PM

Discussion

NEUROSURGICAL

CME Hours:

2 Category I

Date:

Monday, May 3 & Tuesday, May 4

Place:

Annual Dinner OSNS — Racquet
Club

Breakfast/Meeting — Van Cleve III,
Stouffer's

Socioeconomic Meeting — Rooms
304-305, Convention Center

Lunch — Van Cleve III, Stouffer's

Scientific Session — Rooms
304-305, Convention Center

Time:

7 PM, May 3 & 7 AM to 3:30 PM,
May 4

Sponsor:

OSMA Section on Neurosurgery
and the Ohio State Neurosurgical
Society

Schedule:

7 PM, Monday May 3

(7 PM Cocktails

8 PM Dinner)

Annual OSNA Dinner

Racquet Club, Dayton

Winters Bank Bldg.

Corner 2nd & Main Street

— *Dr. Bert McBride, Honored*

Guest

7 AM to 8:30 AM, May 4

Breakfast/Business Meeting

Van Cleve III, Stouffer's

(Election of Officers and Other
Business will be discussed)

9 AM to 12 Noon

Socioeconomic Considerations

1. Presentation of JSEC

Activities and Discussion.

2. "State of the State," by
OSMA President, Dr. Stewart
B. Dunsker.

3. Presentation of the new
concept of competition bills
being introduced at the
Federal level, by D. Brent
Mulgrew, Esq., Director,
OSMA Department of
Legislation.

12 Noon

Luncheon

Van Cleve III, Stouffer's

1:30 - 3:30 PM

Scientific Session

1:30 - 2:00 PM

"Is Stroke A Progressive
Disorder?"

— *Julian Hoff, M.D., Guest*

Speaker

Professor and Chairman

Department of Neurosurgery

University of Michigan

Ann Arbor, Michigan

2:00 - 2:30 PM

"Protection From Cerebral
Ischemia by Pharmacologic
Agents"

— *Robert Spetzler, M.D.*

Associate Professor,

Neurosurgery

Case Western Reserve University
Cleveland

2:30 - 3:00 PM

"The Role of Lipids in Ischemic

Neurosurgical (continued)

Cerebral Syndromes''

— *George Prioleau, M.D.*
Assistant Professor, Dept. of
Neurosurgery
University of Cincinnati
Cincinnati

3:00 - 3:30 PM

Panel Discussion & Question
Period

Moderator:

Robert McLaurin, M.D.
Professor and Chairman
Department of Neurosurgery
University of Cincinnati
Cincinnati

Panelists:

Drs. Hoff, Spetzler and Prioleau

PEDIATRICS

Date:

Friday, April 30

Place:

Van Cleve IV, Stouffer's Dayton
Plaza Hotel

Time:

9:00 AM to 12:00 Noon

Sponsor:

Ohio Chapter/American Academy
of Pediatrics

Chairman:

Leonard P. Rome, M.D., Shaker
Heights, Ohio

Topic:

Open Executive Committee Session
Ohio Chapter/American Academy
of Pediatrics

Program Description:

National Scene — Task Force
To Promote Pediatrics, AAP Spring
Executive Board Meeting, Pediatric
Resolution Presented at OSMA
Meeting, Insurance Coverage for
Child Health Supervision,
Recommendations For
Comprehensive Care For Children
and Youth, Chapter Chairmen's
Forum (September, 1982), and
Future of Pediatrics.

PLASTIC SURGERY

CME Hours:

3 Category I

Date:

Wednesday, May 5

Place:

Van Cleve I, Stouffer's Dayton
Plaza Hotel

Time:

9:00 AM to 12:00 Noon

Sponsor:

OSMA Section on Plastic Surgery
and Ohio Society for Plastic and
Reconstructive Surgeons

Schedule:

9:00 - 9:10 AM

Introduction: Development of
Surgical Remedies for Obesity
— *Dan W. Elliott, M.D.*
Chairman, Department of
Surgery
Wright State University
Dayton

9:10 - 9:20 AM

Gastric Partitioning
— *William G. Pace III, M.D.*
Columbus

9:20 - 9:35 AM

Gastric Partitioning, Five Years'
Experience
— *Edward W. Martin, Jr., M.D.*
Department of Surgery
Ohio State University
Columbus

9:35 - 9:50 AM

Our Experience with Gastric
Stapling for Morbid Obesity
— *Luis Rodriguez-Baz, M.D.*
Dayton

9:50 - 10:05 AM

Gastric By-pass and Horizontal
Gastric Partitioning: Comparison
and Results
— *George W. Lecliner, M.D.*
Dayton

10:05 - 10:15 AM

Coffee Break

10:15 - 10:25 AM

Abdominoplasty
— *Walter Roettinger, M.D.*
Plastic Surgeon
Wright Patterson Medical Center
Dayton

10:25 - 10:35 AM

Body Contouring after Massive
Weight Loss
— *Reggie Sherrill, M.D.*

Dayton

— *Ranachandra Ramnath, M.D.*
Associate Clinical Professor
Wright State University
Dayton

10:35 - 10:45 AM

Reconstructive Surgery after
Massive Weight Loss
— *Robert L. Ruberg, M.D.*
Associate Professor of Surgery
The Ohio State University
Columbus

10:45 - 10:55 AM

Total Body Contouring
— *Elvin G. Zook, M.D.*
Director, Plastic Surgery Division
Southern Illinois University
School of Medicine
Springfield, Illinois

10:55 - 11:10 AM

Panel Discussion
— *Philip A. Weisman, M.D.*,
Moderator

11:10 - 11:20 AM

Extremity Replantation: The
Cleveland Experience
— *A. Scott Earle, M.D.*
Director, Division of Plastic
Surgery
Cleveland Metropolitan General
Hospital
Cleveland

11:20 - 11:30 AM

Long-term Results of Major
Extremity Revascularization
— *David Postlewaite, M.D.*
Columbus

11:30 - 11:40 AM

The Toledo re-Connection
— *John Robinson, M.D.*
Toledo

11:40 - 11:50 AM

When Not to Replant Extremities
— *Richard O. Gregory, M.D.*
Assistant Professor, Surgery
University of Cincinnati Medical
Center
Cincinnati

11:50 AM - 12:00 Noon

Panel Discussion
— *Elvin G. Zook, M.D.*,
Moderator

12:00 Noon

Adjourn

12:45 PM

Luncheon and Business Meeting
Racquet Club
29th Floor
Winters Bank Tower
Dayton

(continued on page 272)

Famous Pairs.

They work so well together.

One of man's most amazing explorations and scientific adventures, the successful Gemini flight program was a triumph of imagination and—teamwork. Two men learned to operate in space, to rendezvous, to dock, and to work outside their spacecraft in the hard vacuum of outer space. Not only did they coordinate their efforts with ground backup, they also complemented each other's activities within the close confines of the space capsule.



Anusol-HC[®] & Tucks[®]

...another well-known pair that works so well together! Ninety-five percent of colon/rectal surgeons surveyed* added Tucks pads concomitantly to hemorrhoidal treatment programs they recommended.



Anusol-HC[®] Suppositories/Cream with Hydrocortisone Acetate

The #1 physician-prescribed product for hemorrhoids and other common anorectal disorders**

- ☐ Antiinflammatory, to relieve edema, burning, itching, pain
- ☐ Astringent, to help promote healing
- ☐ Emollient, for easier bowel movements and soothing relief of local trauma

And, when pain is a special problem, Anusol Ointment offers the benefits of the anesthetic, pramoxine HCl.

TUCKS[®] Pre-Moistened Hemorrhoidal/Vaginal Pads

The #1 hemorrhoidal pad* for added external relief and gentle cleansing of fecal residue

- ☐ Soothes, cools, comforts the irritation and itch of hemorrhoids and other common anorectal disorders
- ☐ Hygienic rectal wipe—an integral part of the anorectal regimen

Once pain and inflammation subside, for dual action recommend regular ANUSOL[®]—to maintain patient comfort—and TUCKS[®]—to maintain patient anorectal hygiene.

ANUSOL-HC[®] Suppositories/ ANUSOL-HC[®] Cream

Before prescribing, please see full prescribing information. A Brief Summary follows:

Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in external and internal hemorrhoids, proctitis, papillitis, cryptitis, and fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol[®] Suppositories or Ointment.

CONTRAINDICATIONS

Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

WARNINGS

The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

PRECAUTIONS

General

Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.

Pregnancy

See "WARNINGS."

Pediatric Use

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

DOSE AND ADMINISTRATION

Anusol-HC Suppositories—Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

Store between 59°-86°F [15°-30°C]

1089G010

PARKE-DAVIS

Warner-Lambert Company
Morris Plains, NJ 07950

**WARNER
LAMBERT**

* Meeting of Am Soc Colon/Rectal Surgeons, May 1980

** Based on total prescriptions filled for hemorrhoidal preparations during the first three quarters of 1981. The National Prescription Audit, IMS America Ltd, Sept 1981.

* 1981 data from leading marketing research organization.

PATHOLOGY

CME Hours:

5 Category I

Date:

Tuesday, May 4

Place:

Room 302, Dayton Convention Center

Time:

9:00 AM to 4:30 PM

Sponsor:

OSMA Section on Pathology and the Ohio Society of Pathologists

Schedule:

9:00 - 11:30 AM

Not complete at time of

publication

11:30 AM to 12:30 PM

Business meeting OSP

12:30 - 1:30

Lunch

1:30 - 3:00 PM

Slide Seminar on Tumors of the Lung Mediastinum

— Presented by:

*Darryl Carter, M.D.*Department of Pathology
Yale University School of Medicine

New Haven, Connecticut

3:00 - 3:20 PM

Coffee Break

3:20 - 4:30 PM

Continuation of Slide Seminar

PSYCHIATRY

CME Hours:

4 Category I

Date:

Sunday, May 2

Place:Council Meeting/Breakfast — Roof Top Room, Sheraton
OPA Meeting — Roof Top Room, Sheraton
Luncheon — Glenn Room, Sheraton
Academic Program — Wright Brothers Room, Sheraton**Time:**

8:00 AM to 5:00 PM

Sponsor:

Ohio Psychiatric Association and OSMA Section on Psychiatry and Neurology

Schedule:

8:00 - 11:00 AM

OPA Council Meeting/Breakfast
Roof Top Room, Sheraton

11:00 - 11:30 AM

OPA Research and Education
Foundation Meeting
Roof Top Room, Sheraton

11:30 - 1:00 PM

Luncheon and Installation of
New President
Glenn Room, Sheraton

1:00 - 5:00 PM

Academic Program
Epidemiology and Assessment of
Suicide Potential in the
Adolescent Patient

Epidemiology

Affective and other disorders
associated with Suicide
Psychodynamic Factors
Videotape presentation of case
discussion and questions from
audience

Faculty:

*Jerald Kay, M.D.*Assistant Professor of Child
Psychiatry
University of Cincinnati College
of Medicine

Cincinnati

*Rena L. Kay, M.D.*Assistant Professor of Child
Psychiatry
University of Cincinnati College
of Medicine and Director,
Adolescent Inpatient Psychiatric
ServiceCincinnati General Hospital
Cincinnati*David Shaffer, M.D.*Professor of Clinical Psychiatry
and PediatricsColumbia University College of
Physicians and Surgeons and
Author on Epidemiology of
Adolescent Suicide (Am. J. Child
Psych. 20:1981)
New York, New York

PFIZER DIALOGUE PRESENTATIONS

CME Hours:

1 Category I (each presentation)

Date:

Monday, May 3

Place:

Room 203, Dayton Convention Center

Time:

9:00 AM to 3:00 PM

Sponsor:OSMA Committee on Program in
cooperation with Pfizer
Pharmaceuticals**Schedule:**

9:00 - 10:00 AM

Management of the Ambulatory
Diabetic— *Sean Nolan, M.D.*Associate Professor of Medicine
University of Pittsburgh
Pittsburgh, Pennsylvania

10:30 - 11:30 AM

Pathophysiology and Office
Management of Hypertension
— *Sean Nolan, M.D.*

1:30 - 2:30 PM

Dermatitis

— *Willard Steck, M.D.*Head of Clinical Dermatology
Department of Dermatology
Cleveland Clinic
Cleveland, Ohio

2:30 - 3:00 PM

Film: Angina Pectoris — New
Concepts/New Treatment

PHYSICAL MEDICINE & REHABILITATION

CME Hours:

3 Category I

Date:

Sunday, May 2

Place:

Room 207, Dayton Convention Center

Time:

2:00 to 5:00 PM

Physical Medicine & Rehabilitation (continued)

Sponsor:

OSMA Section on Physical Medicine and Ohio Society of Physical Medicine and Rehabilitation

Presiding Officer:

Watson D. Parker, Jr., Dayton

Schedule:

12:00 Noon
Luncheon/Business Meeting
Van Cleve IV, Stouffer's

2:00 - 3:00 PM

Athletic Conditioning of Non-Athletes
— Roger M. Glaser, Ph.D.
Professor of Physiology
Director of the Laboratory of Applied Physiology
Wright State University School of Medicine
Dayton

3:00 - 3:15 PM

Coffee and Soft Drinks Break

3:15 - 5:00 PM

Exercise, Stress, Fitness
Evaluation and Training of Wheelchair Users
— Roger M. Glaser, Ph.D.

Presiding Officer:

Jerome H. Herman, M.D.
Cincinnati

Schedule:

12:00 Noon - 1:15 PM
Luncheon
Van Cleve III, Stouffer's

1:30 - 2:00 PM

Childhood Dermatomyositis
— William E. Crowe, M.D.
Assistant Professor of Medicine
Division of Chronic Diseases
Metropolitan General Hospital
Cleveland

2:00 - 2:30 PM

Kawasaki Disease — Its Place in the Spectrum of Childhood Vasculitis
— Robert M. Rennebohm, M.D.
Clinical Research Scholar
Department of Pediatrics

University of Cincinnati College of Medicine
Cincinnati

2:30 - 3:00 PM

Common Orthopedic Problems of Childhood
— Alvin H. Crawford, M.D.
Director of Orthopedic Surgery
Children's Hospital Medical Center
Cincinnati

3:00 - 3:30 PM

Coffee Break

3:30 - 4:00 PM

The Diagnosis, Classification and Management of Juvenile Rheumatoid Arthritis (JRA)
— Joseph E. Levinson, M.D.
Professor of Medicine and Pediatrics
Divisions of Immunology and

Coming in the MAY JOURNAL:

- Personality Styles, Stress Factors and Antidepressants
- A Visit with an English G.P.
- Dr. O'Leary

RHEUMATOLOGY

CME Hours:

3 Category I

Date:

Monday, May 3

Place:

Room 204, Dayton Convention Center

Time:

12:00 Noon to 5:00 PM

Sponsor:

OSMA Section on Rheumatology and the Ohio Rheumatism Society

Program Director:

William E. Crowe, M.D.
Cleveland

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Rheumatology (continued)

Pediatric Rheumatology
University of Cincinnati College
of Medicine
Cincinnati

4:00 - 4:30 PM

The Immunopathogenesis of JRA
— *James T. Cassidy, M.D.*

Professor of Medicine
Rackham Arthritis Unit
University of Michigan
Ann Arbor, Michigan

4:30 - 5:00 PM

Panel Discussion
— *William E. Crowe, M.D.*,
Moderator
Panelists: Drs. Cassidy,
Crawford, Levinson and
Rennebohm

SPORTS MEDICINE

Date:

Monday, May 3

Registration Fee:

\$15.00

Place:

Room 303, Dayton Convention
Center

Time:

9:00 AM to 4:30 PM

Sponsor:

OSMA Section on Sports Medicine

Schedule:

9:00 - 9:10 AM

Introduction

— *Robert K. Finley, Jr., M.D.*
Chairman, OSMA Section on
Sports Medicine
Dayton

9:10 - 9:30 AM

When Can the Player Return to
the Game?

— *William Whitaker, M.D.*
Physician for Kettering Public
School
Athletic Department
Kettering

9:30 - 9:50 AM

On-The-Field Diagnosis of Head
& Neck Injuries

— *Frank Manarino, M.D.*
Director of Sports Medicine
Department
St. Elizabeth's Hospital
Dayton

9:50 - 10:10 AM

Prevention of Heat Illness
— *Robert J. Murphy, M.D.*
Ohio State Football Team
Physician
Columbus

10:10 - 10:20 AM

Break

10:20 - 11:00 AM

Conditioning to Prevent Injuries
— *Reginald L. Richard*
Chief Physical Therapist
Miami Valley Hospital
Dayton

11:00 - 11:30 AM

Management of Common Sports
Injuries
— *Ken Wolfert, ATS*
Director, SW Ohio Sports
Medicine Center
Hamilton

11:30 - 12:30 AM

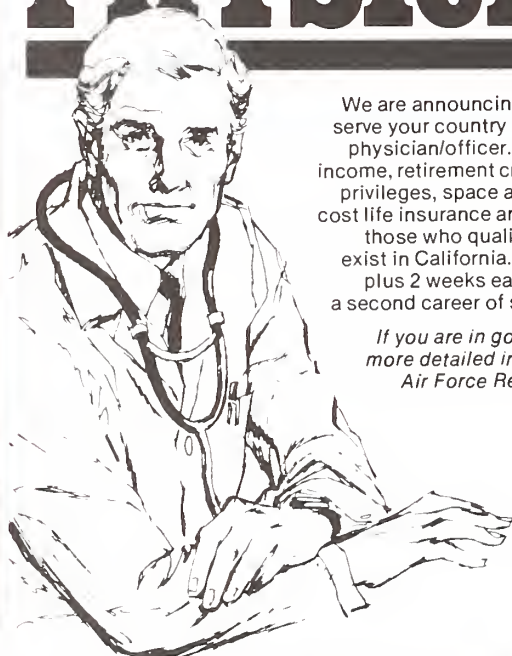
Lunch
Van Cleve I & II, Stouffer's
Dayton Plaza

1:00 - 4:30 PM

Workshop Session

1. Bandaging & Taping
Techniques
Ken Wolfert
David Shon, Head Athletic
Director
Wright State University
Dayton
2. Conditioning Routine
Reginald L. Richards
3. Robert Murphy, M.D.
4. Frank Manarino, M.D.
5. William Whitaker, M.D.

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TRAUMA

CME Hours:

3 Category I

Date:

Monday, May 3

Place:

Room 207, Dayton Convention Center

Time:

9:00 AM to 12:00 Noon

Sponsor:

Ohio Committee on Trauma, A.C.S.

Topic:

Office Management of Emergencies and Trauma

Schedule:

9:00 - 9:20 AM

Hand Injuries

— *Ronald E. Hodges, M.D.*

Assistant Clinical Professor,

Orthopedic Surgery

Wright State University

Dayton

9:20 - 9:30 AM

Questions and Answers

9:30 - 9:50 AM

ENT Emergencies

— *Jerry Spiegel, M.D.*

Assistant Clinical Professor of

Otolaryngology

Wright State University

Dayton

9:50 - 10:00 AM

Questions and Answers

10:00 - 10:20 AM

Eye Emergencies

— *John D. Bullock, M.D.*

Dayton

10:20 - 10:30 AM

Questions and Answers

10:30 - 10:50 AM

Genitourinary

— *S. Henry Dimlich, M.D.*

Dayton

10:50 - 11:00 AM

Questions and Answers

11:00 - 11:20 AM

Management of Minor Burns

— *Sidney F. Miller, M.D.*

Dayton

11:20 - 11:30 AM

Questions and Answers

12:00 Noon

Luncheon

WRIGHT STATE DAY

CME Hours:

6 Category I

Date:

Monday, May 3

Place:

Rooms 304 & 305, Dayton Convention Center

Time:

9:00 AM to 4:00 PM

Sponsor:

Wright State University School of Medicine in cooperation with the OSMA and OSMA Second District

Schedule:

8:30 AM

Registration

8:50 AM

Welcome and Introduction to:
The Wright Approach to
Infectious Diseases

Morning Session Presided over
by:

— *A. Robert Davies, M.D.*

9:00 AM

Internal Medicine

Approach to Infectious Diseases:
Wright in the Office

Howard F. Wunderlick, M.D.

Assistant Professor in Medicine

Wright in the Hospital

Jorge Crespo, M.D.

Assistant Professor in Medicine

New Antibiotics: Wright or
Wrong

H. Bradford Hawley, M.D.

Associate Professor in Medicine

Host Resistance Factors Affecting
Infectious Disease

Moshe Torem, M.D.

Associate Professor in Medicine

10:20 AM

Questions and Answers

10:30 AM

Break — with opportunity to ask
questions of previous presenters
(Refreshments courtesy OSMA
2nd District)

10:45 AM

Pediatrics

Otitis Media

Thomas Murphy, M.D.

Sore Throat

Ralph E. Haynes, M.D.

11:45 AM

Questions and Answers

12:00 Noon

Lunch Break

Afternoon Session presided over
by:

— *W. Jack Lewis, M.D.*

1:00 PM

Sexually Transmitted Diseases of
1982

— *William D. Sawyer, M.D.*

Dean

Wright State University School
of Medicine

1:30 PM

Obstetrics/Gynecology

Pelvic Inflammatory Disease,

Diagnosis, Etiology & Treatment

— *R. Dillaplain, M.D.*

2:00 PM

Surgery

Abdominal Sepsis: Multiple

Organ Failure & Its Management

— *Sidney Miller, M.D.*, Assistant

Director

Surgical Education

Miami Valley Hospital

2:30 PM

Break: with opportunity to ask
questions of previous presenters
(Refreshments courtesy OSMA
2nd District)

2:45 PM

Multidisciplinary Panel Spotlight
on Difficult Medical Decisions.
The ethical and legal dilemmas
of infectious diseases as
highlighted by case
presentations and analyses, ie,
ethics of reportable diseases,
ethical and moral and legal
issues in life and death issues,
etc.

Wright State Day (continued)

John C. Gillen, M.D., Moderator

Panel Members:

Robert Reece, Ph.D.

Marshall Kapp, J.D., M.P.H.

Moshe Torem, M.D.

3:45 PM

Questions and Answers for
above program

Post Program Critique

4:15 PM

30-Minute Wine and Cheese

Reception for Presenters and

Attendees

Hosted by OSMA 2nd District

COLON AND RECTAL SURGERY

CME Hours:

4 Category 1

Date:

Tuesday, May 4

Place:

Room 203, Dayton Convention
Center

Time:

1:00 to 5:00 PM

Sponsor:

OSMA Section on Colon and
Rectal Surgery

Schedule:

11:30 AM to 1:00 PM

Luncheon

Van Cleve IV, Stouffer's

1:00 to 5:00 PM

Early Detection of Colon and
Rectal Cancer

Speakers:

Paul S. Anseline, M.D.

Stow

Thomas G. Hardy, Jr., M.D.

Columbus

Robert Ludwig, M.D.

Columbus

Edward W. Martin, Jr., M.D.

Columbus

Mrs. Sally J. Thompson

Enterostomal Therapist

Worldwide Ostomy Center, Inc.

Akron

INTERNAL MEDICINE

CME Hours:

4 Category 1

Date:

Sunday, May 2

Place:

Room 204, Convention Center

Time:

1:00-5:00 PM

Sponsor:

OSMA Section on Internal
Medicine and Ohio Society of
Internal Medicine

Schedule:

1-1:50 PM

Medically Curable Malignancies

—*Ronald Fletcher, M.D.*

Dayton

1:50-2:30 PM

The Changing Scene in

Diagnosis and Treatment of

(continued on page 285)

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1. Promoting Health/Preventing Disease: Objectives for the Nation. U.S. Department of Health and Human Services, November 1980.
*An *in vitro* simulation of gastric ulcer acid level conditions based on standard laboratory methodology. Data on file. Ayerst Laboratories.
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(216) 696-8044

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Pre-Columbian Art and Antiquities

A special exhibit sponsored by OSMA's Art and Culture Committee

The OSMA's Committee on Art and Culture invites you to add a little spice to your Annual Meeting visit. The Committee is sponsoring, in addition to the traditional photography contest, an exhibit of Pre-Columbian art.

The art is on loan from Jack Singer, M.D., Cincinnati. Dr. Singer collected the approximately 30 pieces of Pre-Columbian pottery during his travels in Central and South America. He also

credits his colleague, David Pixley, M.D., West Union, with his help in collecting artifacts while attending medical school in Guadalajara, Mexico.

Some of the pieces of pottery date back before the time of Christ. All were made by Indians before 1492.

Make plans now to stop by the Dayton Room in Stouffer's. The exhibit will be open Saturday, May 1, through Tuesday, May 4, from 9:30 to 5:30.

Harry Fox, M.D., Chairman of the Art and Culture Committee, invites other OSMA members who have any type of Pre-Columbian or Central and South American art antiquities to contact him. The Committee is very interested in expanding the exhibit. His address is 368 Doctor's Building, 19 W. Eighth, Cincinnati, Ohio 45202, or call him at 513/621-4311.

For those artistic licensed physicians

While the Ohio State Medical Association's (OSMA) Art and Culture Committee is currently making strides in promoting physician art around the state, there is one group that has been making such advances, nationally, for nearly 50 years.

The American Physician Art Association (APAA) was formed in 1936 as a national nonprofit organization with a membership that

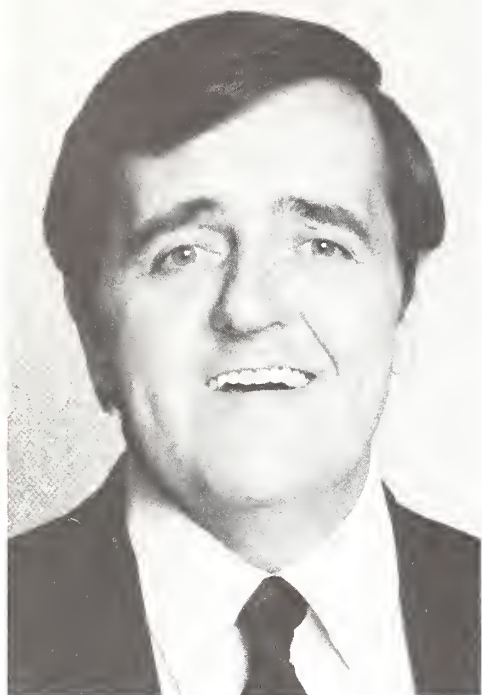
extends not only across the entire United States, but over Canada and Latin America as well. Among the group's goals, as established by founder, Francis H. Redewill, Sr., M.D., are:

- To promote an appreciation of art among the medical profession.
- To stimulate physician artists to produce works of art in the fields of

(continued on page 308)



"Desert Fantasy" (above) created by Victor Laughlin, M.D., Cleveland, and "The Return," an oil painting by Vijay G. Mistry, M.D., each took first place honor in its class at the APAA exhibit held at the South Medical Association's annual meeting.



OMPAC LUNCHEON

Date: Saturday, May 1

Place: Van Cleve Ballroom
Stouffer's Dayton Plaza
Dayton, Ohio

Time: 12:00 Noon

Fee: \$15 per person

Speaker: Mark Shields

After managing political campaigns — from the courthouse to the White House — in some 38 states; after teaching on the subject of American politics and the press, not only at Harvard University, but at the Wharton School of the University of Pennsylvania; after analyzing the results of national conventions and elections for both CBS and NBC news . . . what is a young, political manager to do?

If you're Mark Shields, you turn journalist. After a successful career as a political manager (during which he accomplished all of the above), Mark Shields now writes a column for the *Washington Post*, which is syndicated nationally by the Chicago Tribune New York News

syndicate. As a broadcast journalist, he hosts his own weekly television news show "Inside Washington," produced by the Maryland Center for Public Broadcasting, and seen in 46 cities. He also does three weekly television commentaries over the Cable News Network.

And he speaks, publicly, about his experiences in the field — first-hand accounts about some of the most important political events in the past 20 years. You won't want to miss a word of it. Fill out the coupon below, and plan on spending Saturday, May 1, at the OMPAC Luncheon. Mark Shields is bound to make it an interesting afternoon for everyone — Republican and Democrat alike.

Make check payable to: The Ohio State Medical Association

Saturday, May 1

12:00 Noon — OMPAC Luncheon

Van Cleve Ballroom, Stouffer's Dayton Plaza

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ALLEN COUNTY

Delegates:
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Gene E. Wright
Alternates:
Thomas R. Leech

AUGLAIZE COUNTY

Delegate:
James Romaker
Alternates:
Herbert S. Wolfe
Thomas C. Dozier

CRAWFORD COUNTY

Delegate:
C. H. Yang
Alternate:
David Chan

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Delegate:
William H. Kose
Alternate:
George Hassink

HARDIN COUNTY

Delegate:
Leonard K. Smith
Alternate:
Robert A. Thomas

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Delegate:
James H. Steiner
Alternate:

MARION COUNTY

Delegate:
Paul E. Lyon

Alternate:
D. Lee Johnson

MERCER COUNTY

Delegate:
James J. Otis
Alternate:
Donald R. Fox

SENECA COUNTY

Delegate:
James A. Murray
Alternate:
John F. Vela

VAN WERT COUNTY

Delegate:
James L. Evans
Alternate:
Jerry Sell

WYANDOT COUNTY

Delegate:
Donald P. Smith
Alternate:
Konstantin K. Solacoff

4th District

DEFIANCE COUNTY

Delegate:
Nilo Gomez
Alternate:
Benedict B. Lenhart

FULTON COUNTY

Delegate:
Vernon L. Cotterman
Alternate:
David A. Thompson

HENRY COUNTY

Delegate:
Wilson J. Stough
Alternate:
Raymond J. Manahan

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Delegates:
John A. Devany
Frank E. Foss

Roland A. Gandy, Jr.
B. Leslie Huffman
James A. Jagodzinski
Jerome Kimmelman
Thomas J. O'Grady
Peter A. Overstreet
Richard J. Wiseley

Alternates:
Arturo Castillo
Donnan B. Harding, Jr.
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Frederic C. Henry
Howard S. Madigan
Antonio B. Paat
S. Theodore Pinsky
Lance A. Talmage
John J. Newton

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Alternate:
Vincent Wm. Wagner

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Alternate:
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Alternate:
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Delegate:
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Alternate:
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Delegate:
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Alternate:
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Delegate:

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Alternate:

Albin F. Urankar

CUYAHOGA COUNTY

Delegates:

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D. A. Baumgartner, Jr.

Wilma F. Bergfeld

Theodore J. Castele

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Robert C. Grotz

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Charles Koster

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Lawrence H. Malm

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GEAUGA COUNTY

Delegate:

Bruce F. Andreas

Alternate:

Oscar Brinckmann

LAKE COUNTY

Delegates:

John Bukovnik

Harry Killian

Alternates:

David Farrington

Ronald Taddeo

6th District

COLUMBIANA COUNTY

Delegate:

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Alternate:

Leonard S. Pritchard

MAHONING COUNTY

Delegates:

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John C. Melnick

Charles E. Pichette

William E. Sovik

Karl F. Wieneke

Alternates:

George R. Barton

Richard A. Memo

David E. Pichette

Joseph W. Tandatnick

C. Conner White, Jr.

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Delegates:

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E. Joel Davis

Edward E. Grable

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Reich L. Watterson

Alternates:

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George Ewing

Richard Feezel

Jack G. G. Hendershot

David M. Montgomery

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Delegates:

Joseph Sudimack, Jr.

John O. Vlad

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John Biggins

Robert I. Schaffer

7th District

BELMONT COUNTY

Delegate:

Theodore H. Korthals

Alternates:

Nermin D. Lavapies

C. K. Jean

CARROLL COUNTY

Delegate:

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Alternates:

Nan M. Bissell

Jack L. Maffett

COSHOCTON COUNTY

Delegate:

Norman Wright

Alternate:

Robert Johnson

HARRISON COUNTY

Delegate:

Elias Freeman

Alternate:

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JEFFERSON COUNTY

Delegate:

James Cottrell

Alternate:

John E. Holman

MONROE COUNTY

Delegate:

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Alternate:

Donald R. Piatt

TUSCARAWAS COUNTY

Delegate:

Philip T. Doughten

Alternate:

Ben Wherley

8th District

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John F. Kroner, Jr.

Alternate:

Kenneth Woods

FAIRFIELD COUNTY

Delegate:

James Barrett

Alternate:

James Merk

GUERNSEY COUNTY

Delegate:

Robert A. Ringer

Alternate:

LICKING COUNTY

Delegate:

John Anderson

Alternate:

Lawrence A. Dils

MORGAN COUNTY

Delegate:

Austin A. Coulson

Alternate:

Henry Bachman

MUSKINGUM COUNTY

Delegate:

John W. Ray

Alternate:

David L. Klein

NOBLE COUNTY

Delegate:

Frederick M. Cox

Alternate:

Edward G. Ditch

PERRY COUNTY

Delegate:

Ralph E. Herendeen, Jr.

Alternate:

WASHINGTON COUNTY

Delegate:

Gregory B. Krivchenia

Alternate:

Kenneth E. Bennett

9th District

GALLIA COUNTY

Delegate:

Thomas P. Price, Jr.

Alternate:

Daniel H. Whiteley

HOCKING COUNTY

Delegate:

Roy R. Bontrager

Alternate:

Rowan D. Labrador

JACKSON COUNTY

Delegate:

John W. Zimmerly

Alternate:

Carl J. Greever

LAWRENCE COUNTY

Delegate:

John A. Mayer

Alternate:

James B. Zimmerman

MEIGS COUNTY

Delegate:

E. S. Villanueva

Alternate:

PIKE COUNTY

Delegate:

Kenneth A. Wilkinson

Alternate:

SCIOTO COUNTY

Delegate:

George F. White

Alternate:

Daniel Martelino

VINTON COUNTY

Delegate:

Alternate:

10th District

DELAWARE COUNTY

Delegate:

David R. Smith, Jr.

Alternate:

Michael D. Reuter

FAYETTE COUNTY

Delegate:

Robert A. Heiny

Alternate:

Robert U. Anderson

FRANKLIN COUNTY

Delegates:

Homer A. Anderson

Michael A. Anthony

James E. Barnes

J. Richard Briggs

Walter M. Haynes, Jr.

James E. Matson

Paul S. Metzger

George W. Paulson

H. William Porterfield

Jack E. Tetirick

Alternates:

Ben Arnoff

Ronald B. Berggren

Janet K. Bixel

James W. Kilman

William T. Paul

Alexander Pollack

Warren W. Smith

Louis E. Vassy

Robert L. Wall

Claire V. Wolfe

KNOX COUNTY

Delegate:

Henry T. Lapp

Alternate:

Roger H. Sherman

MADISON COUNTY

Delegate:

Sol Maggied

Alternate:

MORROW COUNTY

Delegate:

Alternate:

PICKAWAY COUNTY

Delegate:

Ray Carroll

Alternate:

ROSS COUNTY

Delegate:

Joseph S. McKell

Alternate:

James R. Manchester

UNION COUNTY

Delegate:
Paul R. Zaugg
Alternate:
Walter Burt

11th District

ASHLAND COUNTY

Delegate:
Jon H. Cooperrider
Alternate:
Paul Sauder

ERIE COUNTY

Delegate:
James Hart
Alternate:
William Birmingham

HOLMES COUNTY

Delegate:
Luther W. High
Alternate:
Maurice E. Mullet

HURON COUNTY

Delegate:
Nino M. Camardese
Alternate:
Carl D. Obenauf

LORAIN COUNTY

Delegates:
Charles Adams
John Bartone
Feite Hofman
Alternates:
Francisco Floro
Eugene Socha
Daniel Zaworski

MEDINA COUNTY

Delegate:
Richard Avery
Alternate:
Rolland L. Mansell

RICHLAND COUNTY

Delegates:
James F. Clements
James W. Wiggins
Alternates:
Joel E. Kaye
John A. Savoy

WAYNE COUNTY

Delegate:
A. Burney Huff
Alternate:
John Robinson

12th District

PORTAGE COUNTY

Delegate:
Donald Hammel
Alternate:
Peter Chen

SUMMIT COUNTY

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Charles A. East
Manley L. Ford
Aris W. Franklin
Paul D. Gatewood
Fred F. Somma
Francis J. Waickman
W. Paul Kilway
Alternates:
Fred D. Barton
Joseph J. Bastolla
Armond L. Leiby
Robert E. Marsico
Eldridge G. Morgan
J. Joseph Payton
Michael D. Serene
Jack L. Summers

OSMA OFFICERS

President
Stewart B. Dunsker
President-Elect
C. Douglass Ford
Past President
Robert G. Thomas
Secretary-Treasurer
David A. Barr

OSMA COUNCILORS

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Second District
Herman I. Abromowitz
Third District
Alford C. Diller
Fourth District
Benjamin H. Reed
Fifth District
Edward G. Kilroy
Sixth District
Joseph P. Yut

Seventh District
H. Judson Reamy
Eighth District
Carl E. Spragg
Ninth District
A. Burton Payne
Tenth District
D. James Hickson
Eleventh District
S. Baird Pfahl, Jr.
Twelfth District
Joseph L. Kloss

STUDENT DELEGATES TO OSMA

Case Western Reserve University
School of Medicine
Marc F. Metcalfe
University of Cincinnati College of Medicine
Marvin H. Rorick III
Medical College of Ohio at Toledo
J. R. Sarpa
Northeastern Ohio Universities
College of Medicine
Kathy A. Quinn
Ohio State University College of Medicine
Linda Weber
Wright State University School of Medicine
Alan Davis

Internal Medicine (continued)

Urinary Tract Infection and
Pneumonia
—Jorge H. Crespo, M.D.
Kettering

2:30-2:45 PM
Break

2:45 - 3:30 PM
Update on Cardiac Drugs —
1982
—Calvert Busch, M.D.
Dayton

3:30 - 4:00 PM
Management of Patients with
Previous Thymic Radiation
— Neil D. Martin, M.D.
Dayton

4:00 - 4:30 PM
Clinical Applications of Digital
Vascular Imaging
—Konrad Kircher, M.D.
Dayton

HYPERTENSION:



METHYLDOPA? RESERPINE? INDERAL? COUNTLESS

THOUSANDS WOULD BE BETTER OFF WITH

INDERAL[®]

(PROPRANOLOL HCl) B.I.D.

The sooner, the better.

Today, INDERAL—instead of methyldopa, instead of reserpine.

INDERAL exhibits few of the disturbing side effects of methyldopa and reserpine. Sedation, depression, and impotence are rare.* Tolerance is not likely to occur, as it frequently does with methyldopa. For the vast majority of patients—INDERAL means a step toward improving the quality of life. (INDERAL should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.)*

INDERAL blocks beta-receptor sites *in the heart* to reduce heart rate and cardiac output—reducing cardiac work load—sparing an overburdened heart.

Hypertensive hearts can rest easy with INDERAL. For many—it is ideal, first-step therapy.

INDERAL—the sooner, the better for hypertension—a leading risk factor in coronary heart disease.¹

*Please see following page for Brief Summary of Prescribing Information.



THE MOST WIDELY PRESCRIBED BETA BLOCKER IN THE WORLD

INDERAL® (PROPRANOLOL HCl) B.I.D. FOR HYPERTENSION

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)
Inderal® BRAND OF propranolol hydrochloride A beta-adrenergic blocking agent

BEFORE USING Inderal (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

CONTRAINDICATIONS

INDERAL is contraindicated in: 1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with Inderal, 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta-blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Inderal acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by Inderal's negative inotropic effect. The effects of Inderal and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during Inderal therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, Inderal therapy should be immediately withdrawn. b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when Inderal is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS DURING ANESTHESIA with agents that require catecholamine release for maintenance of adequate cardiac function, beta blockade will impair the desired inotropic effect. Therefore, Inderal should be titrated carefully when administered for arrhythmias occurring during anesthesia.

IN PATIENTS UNDERGOING MAJOR SURGERY beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, Inderal should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since Inderal is a competitive inhibitor of beta receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), Inderal should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOLYCEMIA Because of its beta-adrenergic blocking activity, Inderal may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY The safe use of Inderal in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit.

Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if Inderal is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of Inderal may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura.

Central Nervous System lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory bronchospasm.

Hematologic agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. **Miscellaneous** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

ORAL

DOSAGE AND ADMINISTRATION

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 40 mg Inderal twice daily, whether used alone or added to a diuretic. Dosage may be increased gradually until adequate blood pressure is achieved. The usual dosage is 160 to 480 mg per day. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

While twice-daily dosing is effective and can maintain a reduction in blood pressure throughout the day, some patients, especially when lower doses are used, may experience a modest rise in blood pressure toward the end of the 12 hour dosing interval. This can be evaluated by measuring blood pressure near the end of the dosing interval to determine whether satisfactory control is being maintained throughout the day. If control is not adequate, a larger dose, or 3 times daily therapy may achieve better control.

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

INTRAVENOUS

The intravenous administration of Inderal has not been evaluated adequately in the management of hypertensive emergencies.

OVERDOSAGE OR EXAGGERATED RESPONSE

IN THE EVENT OF OVERDOSAGE OR EXAGGERATED RESPONSE, THE FOLLOWING MEASURES SHOULD BE EMPLOYED:

BRADYCARDIA—ADMINISTER ATROPINE (0.25 to 1.0 mg). IF THERE IS NO RESPONSE TO VAGAL BLOCKADE, ADMINISTER ISOPROTERENOL CAUTIOUSLY.

CARDIAC FAILURE—DIGITALIZATION AND DIURETICS.

HYPOTENSION—VASOPRESSORS, e.g., LEVATERENOL OR EPINEPHRINE (THERE IS EVIDENCE THAT EPINEPHRINE IS THE DRUG OF CHOICE).

BRONCHOSPASM—ADMINISTER ISOPROTERENOL AND AMINOPHYLLINE.

HOW SUPPLIED

INDERAL (propranolol hydrochloride)

TABLETS

No. 461—Each scored tablet contains 10 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 462—Each scored tablet contains 20 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 464—Each scored tablet contains 40 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 468—Each scored tablet contains 80 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

INJECTABLE

No. 3265—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as: 1 ml ampuls in boxes of 10.

Reference: 1 Freis, E.D. Hypertension (Suppl. II) 3:230 (Nov-Dec) 1981

7997/482

Ayerst

AYERST LABORATORIES
New York, N.Y. 10017

DELEGATES AND ALTERNATES SCHEDULE

FRIDAY, APRIL 30

3:00 - 7:00 PM

Registration for OSMA House of Delegates
Outside Assembly Hall, Convention Center

4:00 PM

Councilor District Caucus Meetings
Caucus suites will be posted at the
Registration Desk.

5:30 PM

Dinner for Delegates, Alternates, OSMA
Council and Official Guests
Van Cleve I & II, Stouffer's

7:00 PM

Opening Session, OSMA House of Delegates
Assembly Hall, Convention Center

BUSINESS AGENDA OPENING SESSION

Call to Order

Stewart B. Dunsker, M.D.,
Cincinnati
President

Invocation

Leslie Earl Whitmire, M.D., Toledo

Welcome

John H. Boyles, Jr., M.D., Dayton
President, Montgomery County
Medical Society

Report

Committee on Credentials

Consideration of Minutes of 1981 Annual Meeting

(See July 1981 issue of The Ohio
State Medical Journal)

Introduction of Member, AMA Board of Trustees

Introduction of Honored Guests

PICO Update

William M. Wells, M.D., Newark
Chairman of the Board of
Directors,
Physicians Insurance Company of
Ohio

Report

Mrs. Shirley C. Davies, Troy
OSMA Auxiliary President

Presentation of Special Award to Richard L. Meiling, M.D., Columbus, Consultant to Editorial Board, OSMJ

AMA-ERF Presentations

Philip B. Hardymon, M.D.,
Columbus

Chairman, Ohio Committee on
AMA-ERF

Presentation of Plaques

To past Councilors, retiring AMA
Delegates and Alternates and
Chairmen of Committees

Announcement

Stewart B. Dunsker, M.D.,
Cincinnati

Appointments to the Reference,
Credentials, President's Address,
Resolutions, and Tellers and
Judges of Election Committees.

Elections of Committee on Nominations
Nominations from the floor. One
representative (delegate) from each
Councilor District. The committee
shall report to the second and final
session, Sunday, May 2, 1:00 PM,

its recommendations in the form of a ticket containing nominees for offices to be filled at this meeting as required under the Constitution and Bylaws. Under the rotation plan established in 1963, the committeeman from the Ninth District shall serve as Chairman. The report of the Nominating Committee with respect to all offices except President-Elect shall be posted at the registration desk, earliest time practicable and at least three hours before the final

session of the House of Delegates.

President's Address

Stewart B. Dunsker, M.D.,
Cincinnati

Introduction of Presidents of Other State Societies

Introduction of Representatives of Allied Organizations

Introduction of Resolutions—

Resolutions must be introduced at

this session of the House of Delegates, referred to the Reference Committees on Resolutions, and reported back to the House of Delegates at the Sunday afternoon session before any action can be taken.

Miscellaneous Business

SATURDAY, MAY 1

6:30 - 7:30 AM

Buffet Breakfast for Delegates, Alternates,
OSMA Council and Official Guests
Van Cleve I & II, Stouffer's

7:30 - 11:30 AM

Reference Committee Hearings, Convention Center
Res. Committee No. 1 - Room 302
Res. Committee No. 2 - Room 303
Res. Committee No. 3 - Rooms 304-305
& President's Address
Nominating Committee - Room 306

SUNDAY, MAY 2

9:00 AM

Councilor District Caucus Meetings
Caucus suites will be posted at the
Registration Desk

11:30 AM - 1:00 PM

Registration for OSMA House of Delegates
Outside Assembly Hall, Convention Center

1:00 PM

Final Session, OSMA House of Delegates
Assembly Hall, Convention Center

6:00 PM

Dinner for Delegates, Alternates, OSMA
Council and Official Guests
Van Cleve I & II, Stouffer's

6:45 PM

Continuation of Final Session
Assembly Hall, Convention Center

ORDER OF BUSINESS FINAL SESSION

Introduction of Guests

Presentation of Journal Photographic Awards

Presentation of Art Awards

Report of Committee on Credentials

Election of President-Elect

Report of Committee on Nominations and Election of Other Officers

Election of Secretary-Treasurer
Incumbent, David A. Barr, M.D., Lima, eligible for re-election to one additional three-year term.

Election of Members of The Council
Members of The Council are elected for two-year terms; terms of those representing the odd-numbered districts expire in even-numbered years. First District: Incumbent, John E. Albers, Cincinnati; Third District: Incumbent, Alford C. Diller, Van Wert (not eligible for re-election having served his three two-year terms); Fifth District: Incumbent, Edward G. Kilroy, Cleveland; Seventh District: Incumbent, H. Judson Reamy, New Philadelphia; Ninth District: Incumbent, A. Burton Payne, Ironton; Eleventh District: Incumbent, S. Baird Pfahl, Jr., Sandusky (not eligible for re-election having served his three two-year terms).

Election of Delegates and Alternates to the AMA

Five Delegates and five Alternates to be elected for a two-year term starting January 1, 1983, in compliance with the Constitution and Bylaws of the American Medical Association. The following incumbent Delegates and Alternates will serve for the remainder of 1982, their terms expiring December 31, 1982. Delegates (listed alphabetically): Theodore J. Castele, Cleveland; Jerry L. Hammon, Dayton; H. William Porterfield, Columbus; Jack Schreiber, Canfield; Robert N. Smith, Toledo. Alternates (listed alphabetically): Alford C. Diller, Van Wert; Stewart

B. Dunsker, Cincinnati; Roland A. Gandy, Jr., Toledo; Edward G. Kilroy, Cleveland; Robert G. Thomas, Elyria.

In addition membership data received from the American Medical Association indicates that the Ohio State Medical Association is eligible for four additional Delegates and four additional Alternate-Delegates, effective January 1, 1982, thus, the Ohio State Medical Association House of Delegates will elect four additional Delegates and four additional Alternate-Delegates to be effective May 2, 1982.

In order to maintain an equal number of Delegates and Alternate-Delegates up for election in any year, a system is being devised whereby two Delegates and two Alternate-Delegates will be elected for a two-year term and two Delegates and two Alternate-Delegates will be elected for a one-year term.

All nominees for the offices of AMA Delegates and Alternate Delegates shall run at large. Election of Delegates and Alternate Delegates of the AMA shall be governed by Section 7, Chapter 5, of the OSMA Constitution and Bylaws as revised by the House of Delegates in May 1971.

****SPECIAL ORDER OF BUSINESS**
(after-dinner break)
Installation of 1982-1983 Officers

Reports of Reference Committees
Resolutions Committee No. 1;
Resolutions Committee No. 2;
Resolutions Committee No. 3; and
President's Address.

Miscellaneous Business

Announcement
C. Douglass Ford, M.D., Toledo
President

Unfinished Business

Adjournment

Neurology Symposium

Fifth Annual Symposium on Contemporary Clinical Neurology. July 27-31; Palmetto Dunes Hyatt Resort, Hilton Head Island, South Carolina. Sponsored by Vanderbilt University School of Medicine. For more information, contact: Mrs. Joan Sullivan, Department of Neurology, Vanderbilt University School of Medicine, Nashville, TN. 37212.



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County Society Officers, Executive Directors and Meeting Dates

**Editor's Note: These counties change officers between April and October.*

1st District

Councilor: *John E. Albers, M.D.*, 2350 Auburn Ave., Cincinnati 45219.

ADAMS: Gary Greenlee, M.D., President, 33 E. Second St., Manchester 45144; David E. Pixley, M.D., Secretary-Treasurer, 154 E. Elliott Ave., Peebles 45660. Second Tuesday.

BROWN: Leslie Hampton, M.D., President, Box 5, Sardinia 45171; Walter Ferris, M.D., Secretary-Treasurer, 614 S. High St., Mt. Orab 45154. First or Second Sunday.

* **BUTLER:** Robert A. Love III, M.D., President, 7 Lisa Drive, Hamilton 45013; George T. Manitsas, M.D., Secretary-Treasurer, 1380 N.W. Washington Blvd., Hamilton 45013; Mrs. Joan Williams, Executive Secretary, 111 Buckeye St., P.O. Box 3216, Hamilton 45013, 513/893-1410. Fourth Wednesday, October - May except December.

CLERMONT: George J. Watkins, M.D., President, 147 Cleveland Ave., Milford 45150; William Blake Selnick, D.O., Secretary-Treasurer, Second & Loveland Aves., Loveland 45140. Second Tuesday.

CLINTON: James E. Rose, M.D., President, 287 Webb Road, Wilmington 45177; Thomas J. Willke, M.D., Secretary-Treasurer, 891 W. Locust St., Wilmington 45177. Fourth Tuesday.

* **HAMILTON:** Robert P. Hummel, M.D., President, Dept. of Surgery, U.C. Medical Center, 231 Bethesda Ave., Cincinnati 45267; Richard L. Meyer, M.D., Secretary, 1186 Gleneagle Court, Cincinnati 45238; William J. Galligan, Executive Director, 320 Broadway, Cincinnati 45202, 513/421-7010. Second Tuesday.

HIGHLAND: Contact person - John T. Ward, M.D., c/o Miss Jeanette Carey, Executive Secretary, Highland County Medical Society, Highland District Hospital, 149 E. Main St., Hillsboro 45133.

WARREN: George Rourke, M.D., President, 445 Hoffman Ave., Lebanon 45036; Gary Hayes, M.D., Secretary, 1004 Oregonia Road, Lebanon 45036. Second Tuesday.

2nd District

Councilor: *Herman I. Abromowitz, M.D.*, 226 Troy St., Dayton 45404.

CHAMPAIGN: James B. Hall, M.D., President, 900 Scioto St., Urbana 43078; J. Steven Polsley, M.D., Secretary-Treasurer, 900 Scioto St., Urbana 43078. Second Wednesday.

CLARK: Walter Lawrence, M.D., President, 4 W. Main St., Suite 916, Springfield 45502; David Lawrence, M.D., Secretary, 402 N. Broadmoor Blvd., Springfield 45504; Mrs. Colleen Buscemi, Executive Secretary, 34 W. High St., Room 710, Springfield 45502, 513/324-8618. Third Monday.

DARKE: Samuel M. Brubaker, M.D., President, 307 N. Main St., Arcanum 45304; Jesse L. Heise, M.D., Secretary, Arcanum Medical Center, Arcanum 45304. Third Tuesday.

GREENE: Richard F. Kelly, M.D., President, 1237 N. Monroe Dr., Xenia 45385; Isagani Hernandez, M.D., Secretary-Treasurer, 2365 Dayton-Xenia Road, Beavercreek 45385; Mrs. Virginia Jones, Executive Secretary, 761 Buckskin Trail, Xenia 45385, 513/376-3783. Third Thursday.

* **MIAMI:** Ramen Das, M.D., President, 624 Park Ave., Piqua 45356; Peter E. Nims, M.D., Secretary, 20 South Lane, Troy 45373. First Tuesday.

MONTGOMERY: John H. Boyles, Jr., M.D., President, 1931 Tait Circle Road, Dayton 45429; Blaine L. Block, M.D., Secretary, 3245 Philadelphia Dr., Dayton 45406; Richard G. Tapia, Executive Director, 40 S. Perry St., Suite 100, Dayton 45402, 513/223-1431. Second Thursday except July and August.

PREBLE: John D. Darrow, M.D., President and Secretary, 228 N. Barron St., Eaton 45320.

SHELBY: George J. Schroer, M.D., President, 1731 Letitia Dr., Sidney 45365; Jerome Mestemaker, M.D., Secretary-Treasurer, 322 Second Ave., Sidney 45365. Second Tuesday.

3rd District

Councilor: *Alford C. Diller, M.D.*, Medical Arts Bldg., 140 Fox Road, Van Wert 45891.

* **ALLEN:** Lawrence L. Young, M.D., President, 825 W. Market St., Lima 45805; Roger L. Terry, M.D., Secretary-Treasurer, Orthopaedic Surgeons of Lima, 1220 E. Elm St., Suite 110, Lima 45805; Will Wolf, Executive Secretary, P.O. Box 1647,

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AUGLAIZE: Herbert Wolfe, M.D., President, 405 S. Main St., New Knoxville 45871; Robert P. Gill, M.D., Secretary-Treasurer, 4 Eagle Dr., Minster 45865. First Thursday, Jan., March, May, Sept. and Nov.

CRAWFORD: C. H. Yang, M.D., President, P.O. Box 108, Crestline 44827; H. Morton Brooks, M.D., Secretary, P.O. Box 151, Crestline 44827.

HANCOCK: Alberto Angustia, M.D., President, 1804 Cherry Lane, Findlay 45840; William Alcott, M.D., Secretary, 1818 Chapel Dr. #A, Findlay 45840. Third Tuesday.

HARDIN: Jack C. Lindsey, M.D., President, 60 Washington Blvd., Kenton 43326; Filmore Riego, M.D., Secretary-Treasurer, 921 E. Franklin, Kenton 43326. Second Tuesday.

LOGAN: Thomas Franklin, M.D., President, 212 Irving Ave., Bellefontaine 43311; Roger Kauffman, M.D., Secretary-Treasurer, Oakhill Medical Center, Rt. 2, West Liberty 43357.

* **MARION:** Leonard Janchar, M.D., President, Frederick C. Smith Clinic, 1040 Delaware Ave., Marion 43302; Vernon Nichols, M.D., Secretary-Treasurer, 318 E. Center St., Marion 43302. First Tuesday except June, July and August.

MERCER: Robert W. Albers, M.D., President, 906 N. Cedar St., Coldwater 45828; George H. McIlroy, M.D., Secretary-Treasurer, 123 E. Fayette St., Celina 45822. Third Thursday except June, July and August.

SENECA: H. R. Niemann, M.D., President, c/o Seneca County Medical Society, 423 S. Main St., Fostoria 44830; John F. Vela, M.D., Secretary-Treasurer, c/o Seneca County Medical Society, 423 S. Main St., Fostoria 44830. Third Tuesday except July, August and December.

VAN WERT: Terrence L. Johnson, M.D., President, Medical Arts Bldg., 140 Fox Road, Van Wert 45891; Robert C. Adams, M.D., Secretary-Treasurer, Medical Arts Bldg., 140 Fox Road, Van Wert 45891. Third Tuesday.

WYANDOT: Donald P. Smith, M.D., President, Pennington St., Sycamore 44882; Frederick Winegarner, M.D., Secretary-Treasurer, 8099 E. Wyandot, Upper Sandusky 43351; Gloria Orians,

A.R.T., Executive Secretary, Wyandot Memorial Hospital, 885 N. Sandusky Ave., Upper Sandusky 43351, 419/294-1941, ext. 32. Second Tuesday.

4th District

Councilor: *Benjamin H. Reed, M.D.*, 730 Burr Road, Wauseon 43567.

DEFIANCE: Benedict B. Lenhart, M.D., President, 1075 E. Second St., Defiance 43512; Nilo Gomez, M.D., Secretary-Treasurer, 1400 E. Second St., Defiance 43512. Second Tuesday.

FULTON: David A. Thompson, M.D., President, 405 E. Lutz Road, Archbold 43502; Estela T. Miquiabas, M.D., Secretary-Treasurer, 725 S. Shoop Ave., Wauseon 43567. Saturday, quarterly.

HENRY: William J. Stough, M.D., President, 515 Avon Place, Napoleon 43545; A. A. Lauengco, M.D., Secretary-Treasurer, Belton & Marion Sts., Hamler 43524. First Tuesday.

LUCAS: John J. Newton, M.D., President, P.O. Box 509, Sylvania 43560; Doonan B. Harding, Jr., M.D., Secretary, 1600 Superior, Toledo 43604; Lee F. Walton, Executive Director, 4428 Secor Road, Toledo 43623, 419/473-3200. Fourth Tuesday.

OTTAWA: John F. Bodie, M.D., President, 1130 Lee Ave., Port Clinton 43452; Barry R. Cover, M.D., Secretary-Treasurer, P.O. Box 579, Port Clinton 43452. Second Thursday, October - June.

PAULDING: Kirkwood A. Pritchard, M.D., President, 119 S. Main, Paulding 45879; Don K. Snyder, M.D., Secretary-Treasurer, Route 2, Box 57, Paulding 45879. Third Monday.

PUTNAM: Oliver N. Lugibihl, M.D., President, Box 235, Pandora 45877; Charles Kidd, M.D., Secretary-Treasurer, Box 256, Kalida 45853. First Tuesday.

SANDUSKY: Thomas G. Bambrick, M.D., President, 605 Third Ave., Fremont 43420; John L. Zimmerman, M.D., Secretary-Treasurer, Memorial Hospital, Fremont 43420; Mrs. Patsy J. Reed, Executive Secretary, Memorial Hospital of Sandusky County, Fremont 43420, 419/332-7321. Last Thursday of month.

WILLIAMS: Clarence Bell, M.D., President, 904 Snyder Ave., Montpelier 43543; Richard L. Hess, M.D., Secretary-Treasurer, 442 W. High St., Bryan 43506; Mrs. Rebecca Cape, Executive Secretary, Bryan Medical Group, Inc., 442 W. High St., Bryan 43506, 419/636-4517. Third Tuesday, Jan., Mar., May, July, Sept., Nov.

WOOD: Said Shehata, M.D., President, 960 W. Wooster St., Bowling Green 43402; William Feeman, M.D., Secretary-Treasurer, 640 S. Wintergarden Road, Bowling Green 43402. Third Thursday.

5th District

Councilor: *Edward G. Kilroy, M.D.*, 18099 Lorain Road, Cleveland 44111.

ASHTABULA: Robert L. McTrusty II, M.D., President, 2709 Lake Ave., Ashtabula 44004; Kaveripatn C. Nagaprakash, M.D., Secretary-Treasurer, 2301 West Ave., Ashtabula 44004; Miss Amy Housel, Executive Secretary, P.O. Box 1772, Ashtabula 44004, 216/998-3111. Second Tuesday, Feb., Apr., June, Sept., Nov., Dec.

* **CUYAHOGA:** Robert M. Zollinger, Jr., M.D., President, 2065 Adelbert Rd., Cleveland 44106; Henry G. Krueger, M.D., Secretary-Treasurer, 20997 Lorain Road, Cleveland 44126; Robert A. Lang, Ph.D., Executive Director, 11001 Cedar Road, 6th Floor, 11001 Cedar Road, Cleveland 44106, 216/229-2200. Second Tuesday.

GEAUGA: David C. Mayer, M.D., President, 13221 Ravenna Road, Chardon 44024; Patrawadee Duangjak, M.D., Secretary-Treasurer, Geauga Community Hospital, P.O. Box 249, Chardon 44024; Mrs. Margaret Pace, Executive Secretary, Geauga Community Hospital, P.O. Box 249, Chardon 44024, 216/286-6131. Second Thursday, Jan., Apr., Sept., Nov.

LAKE: Donald M. Patchin, M.D., President, 8451 Mentor Ave., Mentor 44060; Richard S. Toomey, M.D., Secretary-Treasurer, 35355 Martin Road, Willoughby 44094; Mrs. Jan Vargo, Executive Secretary, Lake County Memorial Hospital, 71 E. High St., Painesville 44077, 216/354-2400. Feb., May, Sept. and Nov.

6th District

Councilor: *Joseph P. Yut, M.D.*, 201 Dueber Avenue, SW, Canton 44706.

COLUMBIANA: I. Sreenivas Rao, M.D., President, 7941 S.R. 45, Lisbon 44432; Robert Bakondy, D.O., Secretary-Treasurer, 1048 E. State St., Salem 44460; Mrs. Gilson Koenreich, Executive Secretary, 163 Park Ave., Salem 44460, 216/337-8859. Third Tuesday except June, July, August and December.

MAHONING: Robert M. Kiskaddon, M.D., President, 3511 Market St., Youngstown 44507; H. S. Wang, M.D., Secretary, 10 Dutton Dr., Youngstown 44502; Robert B. Blake, Executive Director, 245 Bel-Park Bldg., 1005 Belmont Ave., Youngstown 44504, 216/747-4956. Third Tuesday, Jan., Mar., May, Sept., Nov., Dec.

STARK: John Carpathios, M.D., President, 376 49th St., NW, Canton 44709; James D. Burkholder, M.D.,

Secretary-Treasurer, 4150 Beldon Village St., NW, #400, Canton 44718; Mrs. Nancy Adams, Executive Secretary, 4150 Belden Village St., NW, Canton 44718, 216/492-3333. Second Thursday.

TRUMBULL: Michael J. Casale, M.D., President, 2390 Parkman Road, NW, Warren 44485; Nigel K. Newman, M.D., Secretary-Treasurer, 3921 E. Market St., Warren 44484; Mrs. Delores B. Bevan, Executive Secretary, 280 N. Park Ave., Warren 44481, 216/394-4556. Third Wednesday except June, July and August.

7th District

Councilor: *H. Judson Reamy, M.D.*, 931 Fourth St., NW, New Philadelphia 44663.

BELMONT: Theodore H. Korthals, M.D., President, Community Clinic, 63 Highway South, Powhatan Point 43942; Nermin D. Lavapies, M.D., Secretary-Treasurer, 1220 Hughes Ave.,

Martins Ferry 43935. Third Thursday, Feb. - Apr., Sept. - Nov.

CARROLL: Robert H. Hines, M.D., President, 625 N. Market St., Minerva 44657; Thomas J. Atchison, M.D., Secretary-Treasurer, P.O. Box 156, Carrollton 44615. Third Tuesday.

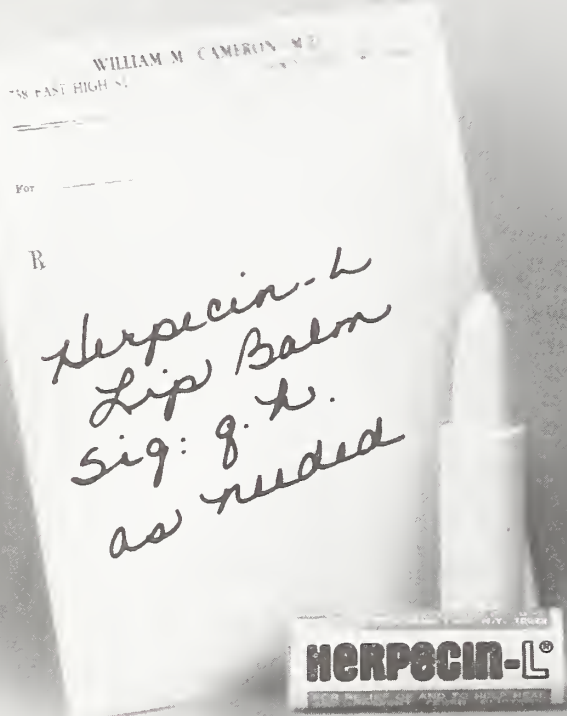
COSHOCTON: Francisco F. Sison, M.D., President, 125 N. Seventh St., Coshocton 43812; Richard Emmons, M.D., Secretary-Treasurer, 646 Chestnut St., Coshocton 43812. Second Tuesday.

HARRISON: Ajit S. Modi, M.D., President, R.D. #1, Cadiz 43907; Siripurapu R. Prasad, M.D., Secretary-Treasurer, Main St., Box 323, Jewett 43986. Second Tuesday.

JEFFERSON: Joseph J. Agresta, M.D., President, 2990 Johnson Road, Steubenville 43952; Dominic N. Ferrara, M.D., Secretary-Treasurer, 108 Brady Circle, Steubenville 43952. First Tuesday.

MONROE: Donald R. Piatt, M.D., President, 154 S. Main St., Woodsfield 43793; Jack M. Matheny II, M.D., Secretary-Treasurer, Monroe County

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TUSCARAWAS: Bharat Oza, M.D., President, 330 N. Water St., Uhrichsville 44633; Umesh Betkerur, M.D., Secretary, 899 E. Iron Ave., Dover 44622. Second Wednesday.

8th District

Councilor: *Carl E. Spragg, M.D.*, 71 W. Main St., New Concord 43762.

ATHENS: Sushila Gawande, M.D., President, 85 Elmwood Place, Athens 45701; John Cunningham, M.D., Secretary-Treasurer, 444 W. Union St., Athens 45701. Second Tuesday, March, June, Sept. Dec.

FAIRFIELD: John G. O'Handley, M.D., President, 600 Pleasantville Road, Lancaster 43130; David H. Sheidler, M.D., Secretary-Treasurer, 1500 E. Main St., Lancaster 43130. Second Tuesday.

GUERNSEY: Jose N. Sayat, M.D., President, 64979 Old 21, Cambridge 43725; Ashfaq H. Siddiqui, M.D., Secretary-Treasurer, 1432 N. Clark St., Cambridge 43725. First Tuesday except July and August.

LICKING: Keith Kulow, M.D., President, 1634 W. Church St., Newark 43055; Hans S. Wee, M.D., Secretary-Treasurer, 1300 Howell Dr., Newark 43055; Mrs. Lindsay Freytag, Executive Secretary, 1320 W. Main St., Newark 43055, 614/366-7317. Fourth Tuesday except June, July, Aug. and Sept.

MORGAN: Asia H. Whitacre, M.D., President, R.D. #1, Chesterhill 43728; Henry Bachman, M.D., Secretary-Treasurer, 426 E. Union Ave., McConnelsville 43756.

MUSKINGUM: Melvin R. Krohn, M.D., President, c/o Muskingum County Academy of Medicine, P.O. Box 2702, Zanesville 43701; Vicki Whitacre, M.D., Secretary-Treasurer, c/o Muskingum County Academy of Medicine, P.O. Box 2702, Zanesville 43701. First Tuesday except June, July and August.

NOBLE: Frederick M. Cox, M.D., President, P.O. Box 330, Caldwell 43724; Edward G. Ditch, M.D., Secretary-Treasurer, P.O. Box 239, Caldwell 43724. First Tuesday.

PERRY: Ralph E. Herendeen, Jr., M.D., President, 203 N. Main St., New Lexington 43764; Stephen A. Ulrich, M.D., Secretary-Treasurer, 203 N. Main St., New Lexington 43764.

WASHINGTON: Aniano B. DeJofes, M.D., President, Marietta Memorial Hospital, Marietta 45750; Tung-Pi Lee, M.D., Secretary-Treasurer, 408 Third St., Marietta 45750. Second Wednesday.

9th District

Councilor: *A. Burton Payne, M.D.*, 411 Center St., Ironton 45638.

GALLIA: Raymond L. Jennings, M.D., President, Holzer Clinic Ltd., P.O. Box 344, Gallipolis 45631; James R. Magnussen, M.D., Secretary-Treasurer, Holzer Clinic Ltd., P.O. Box 344, Gallipolis 45631. Quarterly.

HOCKING: Roy R. Bontrager, M.D., President, Box 987, Logan 43138; James Hayward, D.O., Secretary-Treasurer, 1388 Third St., Logan 43138.

JACKSON: Louis J. Jindra, M.D., President, P.O. Box 316, Oak Hill 45656; Carl J. Greever, M.D., Secretary-Treasurer, 35 Vaughn St., Jackson 45640.

LAWRENCE: James B. Zimmerman, M.D., President, P.O. Box 703, Ironton 45638; David A. Pack, M.D., Secretary-Treasurer, 1230 Navajo Trail, Ironton 45638. Third Thursday, bimonthly.

MEIGS: Selim Blazewicz, M.D., President, P.O. Box 511, Pomeroy 45769; Wilma Mansfield, M.D., Secretary-Treasurer, P.O. Box 351, Pomeroy 45769.

PIKE: Kenneth A. Wilkinson, M.D., President, Hilltop Medical Center, Rt. #2, Waverly 45690; Darrell K. Wells, M.D., Secretary-Treasurer, 216 Emmitt Ave., Waverly 45690.

SCIOTO: Kathryn Skitarelic, M.D., President, 1431 Offnere St., Portsmouth 45662; William T. Esham, M.D., Secretary-Treasurer, 1501 Franklin Ave., Portsmouth 45662; Lowell Thompson, Executive Secretary, P.O. Box 1348, Portsmouth 45662, 614/354-7581. Second Tuesday.

VINTON: No active society.

10th District

Councilor: *D. James Hickson, M.D.*, Box 208, Mt. Gilead 43338.

DELAWARE: Michael D. Reuter, M.D., President, Delaware Radiology, Inc., 561 W. Central Ave., Delaware 43015; Lloyd E. Moore, M.D., Secretary-Treasurer, 141 S. Main St., Prospect 43342. Third Tuesday, Mar., May, Sept., Dec.

FAYETTE: Ralph Gebhart, M.D., President, 616 Willard St., P.O. Box 457, Washington C.H. 43160; Marvin H. Roszmann, M.D., Secretary-Treasurer, 1005 E. Temple, Washington C.H. 43160. Second Friday.

* **FRANKLIN:** George W. Paulson, M.D., President, 931 Chatham Lane, Columbus 43221; Frederik S. Barends, M.D., Secretary-Treasurer, 3360 E. Livingston Ave., Columbus 43227; James S. Imboden, Executive Director, 600 S. High St., Columbus 43215, 614/224-6116. Feb., Aug., Sept., Oct.

* **KNOX:** James H. Risko, M.D., President, 307 Vernedale Dr., Mt. Vernon 43050; Edward Yu, M.D., Secretary-Treasurer, Knox Community Hospital, 117 E. High St., Mt. Vernon 43050. First Wednesday.

MADISON: William T. Bacon, M.D., President, 308 E. High, London 43130; J. Richard Hurt, M.D., Secretary-Treasurer, 35 S. Twin St., West Jefferson 43162. Second Wednesday, quarterly.

MORROW: Joseph P. Ingmire, M.D., President, 28 W. High St., Mt. Gilead 43338; Parviz Meftah, M.D., Secretary, 152 W. High St., Mt. Gilead 43338. First Tuesday.

PICKAWAY: Jasper Hedges, M.D., President, 610 Northridge Road, Circleville 43113; Lynn Chrismer, M.D., Secretary-Treasurer, 610 Northridge Road, Circleville 43113. Second Tuesday.

ROSS: Numeriano Jalbuena, M.D., President, 207 Delano Ave., Chillicothe 45601; Roy Manning, M.D., Secretary-Treasurer, 612 Central Center, Chillicothe 43601. First Thursday.

UNION: Paul R. Zaugg, M.D., President, 225 Stocksdales Dr., Marysville 43040; May B. Zaugg, M.D., Secretary-Treasurer, 509 Hickory Dr., Marysville 43040. First Tuesday, Feb., Apr., Oct., Dec.

11th District

Councilor: *S. Baird Pfahl, Jr., M.D.*,
521 W. Perkins Ave., Sandusky 44870.

ASHLAND: Robert B. Davis, M.D.,
President, 1060 Claremont Ave.,
Ashland 44805; Daniel R. Daugherty,
M.D., Secretary-Treasurer, 350 Hillcrest
Dr., Ashland 44805. First Tuesday.

ERIE: Albert O'Halloran, M.D.,
President, Providence Hospital,
Sandusky 44870; Douglas C. Rist,
M.D., Secretary, 2528 Columbus Ave.,
Sandusky 44870; Mrs. Barbara Wolfert,
Executive Secretary, 2710 Scheid Road,
Huron 44839, 419/433-3097. Second
Tuesday except June, July and August.

HOLMES: Daniel J. Miller, M.D.,
President, Box 143, Walnut Creek
44687; Kim Boyd, M.D., Secretary-
Treasurer, Box 143, Walnut Creek
44687. Second Monday.

HURON: Theodore Ball, M.D.,
President, 423 W. Main St., Bellevue
44811; Ronald Winland, M.D.,
Secretary-Treasurer, 266 Benedict Ave.,

Norwalk 44857. Second Wednesday,
Feb., Apr., June, Oct., Dec.

LORAIN: J. Brian McMillan, M.D.,
President, 215 Morgan St., Oberlin
44074; Hemendra Mehta, M.D.,
Secretary-Treasurer, 905 E. Broad St.,
Elyria 44035; Mrs. Alice Waite,
Executive Secretary, 110 Sheffield
Center, Lorain 44055, 216/324-3093.
Second Tuesday, Sept. - April.

MEDINA: John Kuehn, M.D.,
President, 3375 Hood Road, Medina
44256; H. Linn Mast, M.D., Secretary-
Treasurer, 970 E. Washington St. #201,
Medina 44256; John E. Gerding,
Executive Secretary, 3377 Forest Hills
Dr., Medina 44256, 216/725-5331. Third
Thursday.

RICHLAND: Albert H. Voegelé,
M.D., President, 240 Park Ave.,
Mansfield 44902; Joseph E. Stolfi,
M.D., Secretary-Treasurer, 222 Marion
Ave., Mansfield 44903; Mrs. M. K.
Leggett, Executive Secretary, Mansfield
General Hospital, Mansfield 44903,
419/522-3411. Third Thursday except
June, July and August.

WAYNE: Harry Zink III, M.D.,
President, 1749 Cleveland Road,
Wooster 44691; Daniel Stump, M.D.,

Secretary-Treasurer, 1761 Beall Ave.,
Wooster 44691. Second Wednesday
every second month.

12th District

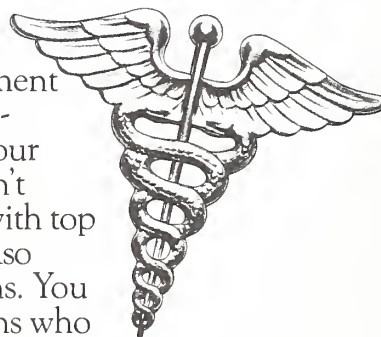
Councilor: *Joseph L. Kloss, M.D.*, 737
Ridgecrest Road, Akron 44303.

PORTAGE: Steve Dean, M.D.,
President, c/o Portage County Medical
Society, 6693 N. Chestnut St., Ravenna
44266; A. N. Can, M.D., Secretary-
Treasurer, c/o Portage County Medical
Society, 6693 N. Chestnut St., Ravenna
44266. Second Tuesday.

SUMMIT: Frank P. Urso, M.D.,
President, Akron City Hospital-
Pathology, Akron, Ohio 44309; Carl W.
Keck, M.D., Secretary, Akron Health
Dept., 177 S. Broadway St., Akron
44308; Mrs. Shirley Bee, Managing
Director, 430 Grant St., Akron 44311,
216/434-1921. Third Wednesday.

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Primary assessment is often futile if measures are not immediately instituted to prevent further deterioration of the clinical status of the trauma patient. The responsibility for appropriate care of critically injured patients rests with the emergency department physician,

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Course Schedule:

Day 1 — Lectures:

Course overview & introduction to ATLS; Initial Assessment; Upper Airway Management; Shock; Thoracic Trauma; Abdominal Trauma

Practical:

Animal Lab — Cricothyroidotomy; Peritoneal Lavage; Pericardiocentesis; Chest decompression/tube insertion — Intubation; Anti-shock garment application; I.V./Shock Therapy

Day 2 — Lectures:

Head Trauma; Neck/Spinal Trauma; Extremity Trauma; Burns; Stabilization and Transport

Practical:

Mr. HURT/Cervical Traction tongs; Extremity Immobilization; Spinal Immobilization; Initial Assessment - Practice/Test; Case Studies; Written Test

General Information:

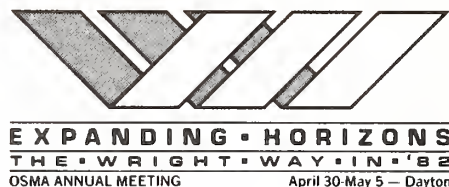
Schedules for ATLS Courses may be obtained from:

Richard B. Fratianne, M.D., Chairman
Ohio Committee on Trauma
3395 Scranton Road
Cleveland, Ohio 44109

Registration: \$250

ENROLLMENT FOR EACH COURSE IS LIMITED TO A TOTAL OF 16 PHYSICIAN PARTICIPANTS.

Credits: 22 Category I hours



Dayton: The Wright Place To Be

By Patricia S. Rab

The Montgomery County Medical Society Auxiliary extends a cordial invitation to all OSMA and OSMAA members and their spouses to join us at any or all of the following exciting and interesting social events which we have planned for the annual OSMAA convention at the Daytonian Hotel in Dayton, April 30 to May 2.

Daytonians need no introduction to D.L. Stewart, whose humorous remarks grace our morning paper several times a week. He is also the author of two books compiled from many of his best columns. On Friday, April 30, he will share his wit with us as the speaker at a dinner to be held at the Daytonian.

On Saturday afternoon you will have a unique opportunity to acquaint yourselves with some of Dayton's historic spots. A narrated Hartline bus tour will take you in comfortable motor coaches for an interesting and informative drive through Dayton — "the City Beautiful." You will be accompanied by experienced tour guides, well qualified to describe Dayton's history. The tour will last about two and a half hours and will bring you back in plenty of time for the evening's festivities.

An International Buffet and Funfest is planned for Saturday evening in the ballroom of the Daytonian Hotel. Among the entertainers will be the

Irish Kerry dancers and the Greek Youth dancers. We hope that as many as are able will wear native costumes to add to the international flavor of the evening, but please don't let the lack of costume keep you from attending this delightful event.

Our installation luncheon on Sunday noon will honor our newly installed president, Rose Vesper, from Hamilton County. We hope that all of you from throughout the State will join Hamilton and Montgomery Counties in this celebration.

For details concerning tickets and reservations for all of these events, please see the registration form in this issue. See you in Dayton!

1982 OSMA Auxiliary Convention Meal Reservation and Activity Registration Form Deadline for all reservations is April 15

Send to: Mrs. James Funkhouser
3320 Southdale Drive
Dayton, Ohio 45409

Make checks payable to: OSMA Auxiliary Convention Fund

No reservations will be accepted unless accompanied by a check.

Reservations will be held in your name at the Registration Desk in the Palm Court of The Daytonian Hotel.

Friday, April 30

7:30 PM Dinner with D. L. Stewart
Ballroom, The Daytonian Hotel _____@ \$16/ticket

Saturday, May 1

2-4:30PM Narrated Bus Tour of Dayton
Lobby, The Daytonian Hotel _____@ \$ 8/ticket

7:30PM International Buffet and Funfest
Ballroom, The Daytonian Hotel _____@ \$20/ticket

Sunday, May 2

12:30PM Installation Luncheon
Ballroom, The Daytonian Hotel _____@ \$12/ticket

TOTAL Enclosed \$ _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

42nd Annual Convention of the OSMA Auxiliary

April 30, May 1 and 2, 1982
The Daytonian - Dayton, Ohio

FRIDAY, APRIL 30

10AM - 8PM	Registration	Palm Court
11AM - 5PM	Hospitality AMA-ERF Boutique County Exhibit Set-up	Rendezvous Room
12 Noon	State Board Luncheon	Ballroom A
1:30 - 3:30PM	State Board Meeting	Ballroom A
	Break	
4-4:30PM	District Caucus Meetings	Ballroom A
	Break	
5-6PM	Bylaws Revision Hearing	Palm Court
5-6PM	Resolutions Committee Meeting	Palm Court
6:30-7:30PM	Social Hour	Ballroom B
7:30PM	Dinner with D. L. Stewart Humorist, Author and Columnist	Ballroom B
7-9PM	OSMA House of Delegates Opening Meeting Auxiliary Presidential Report	Convention Center

SATURDAY, MAY 1

7:45-8:15PM	Complimentary Coffee and Danish	Rendezvous Room
8AM - 5PM	Registration	Palm Court
7:45AM - 5PM	Hospitality AMA-ERF Boutique County Displays	Rendezvous Room
8:30 - 11AM	FIRST BUSINESS SESSION HOUSE OF DELEGATES	Ballrooms A and B
11AM - 12 Noon	Voting Ohio County Walk	Ballroom B Rendezvous Room
12 Noon	OMPAC Luncheon	Van Cleve Room Stouffer's Hotel
12:30PM	Gavel Club Luncheon	Ambassador Room
2-4:30PM	Discover Dayton - "The City Beautiful" Narrated Bus Tour of Dayton	Meet in Hotel Lobby
5-6PM	Orientation for County Presidents-Elect and New State Officers	Ambassador Room
6:30-7PM	Presidential Reception	Ballroom B
7-7:30PM	Social Hour	Ballrooms A and B
7:30PM	International Buffet and Funfest OSMA Delegates and Spouses Invited	Ballrooms A and B

SUNDAY, MAY 2

8AM - 12PM	Registration	Palm Court
8AM - 12PM	Hospitality AMA-ERF Boutique County Displays	Rendezvous Room
8:15 - 8:45AM	Complimentary Coffee and Danish	Rendezvous Room
9-11AM	SECOND BUSINESS SESSION HOUSE OF DELEGATES (Installation at end of session)	Ballrooms A and B
11:30 - 12 Noon	Reception Honoring New President Host: Hamilton County Auxiliary	Palm Court
12:30PM 2:30-3PM	Installation Luncheon (no speaker) Post Convention Board Meeting	Ballrooms A and B Rendezvous Room

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The OSMA Student Section

We resolve . . .

By Louis Saslaw

The first annual meeting of the OSMA Medical Student Section was held on Saturday, February 20th at the OSMA office.

Twenty-four students representing the six Ohio Medical Schools were in attendance.

John Buker, a senior student from Medical College of Ohio, presided.

A brief history of the evolvement of the Medical Student Section was given both by John Buker and Jim Augustine, third-year student from Wright State University.

The MSS then proceeded to act on seventeen resolutions. Of these seventeen, five were passed by the MSS and will be forwarded to the OSMA House of Delegates. These resolutions are described below:

In addition, four more resolutions were passed which will be handled internally by the MSS and do not need House approval.

The last order of business was the election of officers. Frank Papay, NEOUCOM, will serve as OSMA-MSS President for 1982-1983. Mr. Papay will sit on the OSMA Council in a nonvoting capacity.

Dan Watson, NEOUCOM, was elected Vice-President of the MSS. Both Dan and Frank have been active in the medical student membership efforts since those efforts began.*

Alan Mong, Ohio State University, was elected MSS Secretary. Alan's duties will include the establishment of effective communications efforts with Ohio's medical student population.

Six delegates to the OSMA House were also selected. The delegates are:
Ohio State University
Linda Weber

Case Western Reserve University
Marc Metcalfe

NEOUCOM
Kathy Quinn

University of Cincinnati
Marvin Rorick

Wright State University
Alan Davis

Medical College of Ohio
J.R. Sarpa

References

*Dan will be responsible for the educational programs of the MSS.

RESOLUTION

Recognition of the Ohio Cancer Information Service

WHEREAS, The Ohio Cancer Information Service (OCIS) has provided a toll-free informational service for more than 12,000 Ohio health professionals, cancer patients, and the lay public in the past two and one half years; and
WHEREAS, The Ohio Cancer Information Service (OCIS) provides accurate up-to-date information concerning prevention, symptoms, detection, treatment, rehabilitation, and terminal care issues caused by cancer; and

WHEREAS, The National Cancer Institute, The American Cancer Society, and the Ohio State University Comprehensive Cancer Center utilize the OCIS as an informational bridge to the public; and

WHEREAS, The Ohio State Medical Association and the OCIS share the common goals of reducing people's fears of cancer, dispelling cancer myths, and stressing early detection; therefore be it

RESOLVED, that the Ohio State Medical Association and the OSMA Medical Student Section recognize the necessity of the OCIS and make this support known to the federal representatives and senators responsible for its funding.

RESOLUTION

To Establish and Announce MSS Involvement in Community Public Health Affairs Projects

WHEREAS, The Medical Student Section has proposed establishing public service activities; therefore be it

RESOLVED, That the Medical Student Section be available as a clearinghouse and coordinator for communities and public health organizations requesting medical students to participate in programs which will seek to improve the public health; and be it further
RESOLVED, That the Ohio State Medical Association and the Medical Student Section, in their communications with the public and

with public health organizations, announce this function of the Medical Student Section.

RESOLUTION

To Establish a Program Which Would Match Medical Students With Externship and Elective Rotations Available in Ohio

WHEREAS, The Medical Student Section seeks to further the academic experiences of its student members; and
WHEREAS, The services of a medical student would be valuable to physicians, public health organizations, and medical clinics not affiliated with a medical school; therefore be it
RESOLVED, That the Medical Student Section acts as a clearinghouse and coordinator for physicians and public health organizations requesting the services of 3rd or 4th year medical students performing an elective rotation; and be it further
RESOLVED, That the Medical Student Section disseminates

information about this function to the OSMA and its member physicians, county medical societies, and public health organizations.

RESOLUTION

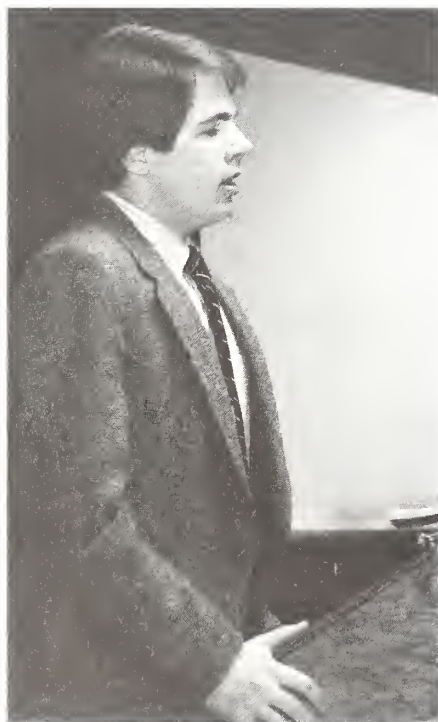
To Establish and Announce a Program Which Would Supply Medical Students as Speakers at Civic and Career-Orientation Programs

WHEREAS, The Medical Student Section represents medical students from all medical schools in Ohio; and
WHEREAS, Many high schools and colleges in Ohio have no affiliation with a medical school; therefore be it
RESOLVED, That the Medical Student Section acts as a clearinghouse and coordinator for high schools, colleges, and civic groups requesting medical students to act as speakers; and be it further
RESOLVED, That the Ohio State Medical Association and the Medical Student Section, in their communications with such groups, announce this function of the Medical Student Section.

RESOLUTION

To Develop Within the MSS Programs Which Would Assist in Improving the Public Health

WHEREAS, The purpose of the Ohio State Medical Association is to provide programs to improve service to the public in matters of personal and public health; and
WHEREAS, The Medical Student Section has as one of its objectives to support the purposes of the Ohio State Medical Association; therefore be it
RESOLVED, That the Medical Student Section participate in public service activities of the Ohio State Medical Association, where its presence is requested by the OSMA; and be it further
RESOLVED, That the Medical Student Section strive to establish programs whereby its members can assist the public through service activities.



Left: John Buker, Medical College of Ohio, served as Acting Chairman during the Meeting. Above: Delegates Linda Weber, Robert McGhee, and Alan Mong from Ohio State University consider one of the resolutions.

(photos by Carol Wright Mullinax)

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Obituaries



FERNANDO MATA, M.D., Mansfield; University of Buenos Aires, Argentina, 1954; age 57; died June 7, 1981; member OSMa and AMA.

JAMES D. PHINNEY, M.D., Cincinnati; University of Pennsylvania School of Medicine, 1940; age 69; died January 18, 1982; member OSMa and AMA.

JAMES L. SAGEBIEL, M.D., Walnut Creek, California; Harvard Medical School, 1927; age 80; died January 30, 1982; member OSMa and AMA.

HAROLD H. STEVENS, M.D., Maumee; Ohio State University College of Medicine; age 87; died February 18, 1982.

FRED E. SPRAGENS, M.D., Cincinnati; University of Cincinnati College of Medicine, 1930; age 76; died January 12, 1982; member OSMa and AMA.

WILLIAM J. TEUFEL, M.D., Rocky River; University of Rochester School of Medicine and Dentistry, 1937; age 70; died January 20, 1982; member OSMa and AMA.

RICHARD C. WOLF, M.D., Mountain View, California; Case Western Reserve University School of Medicine; age 56; died January 15, 1982.

WOODRUFF C. ADAMS, M.D., Toledo; Meharry Medical College School of Medicine, 1952; age 64; died January 24, 1982; member OSMa and AMA.

GEORGE T. BOOTH, M.D., Cape Coral, Florida; University of Michigan Medical School, 1938; age 71; died January 26, 1982; member OSMa and AMA.

GEORGE J. GENSEMER, M.D., Bellefontaine; Jefferson Medical College, Thomas Jefferson University, 1947; age 59; died January 18, 1982; member OSMa and AMA.

IBRAHIM H.N. HABIBY, M.D., Cincinnati; Medical School, American University of Beirut, Lebanon, 1943; age 62; died January 19, 1982; member OSMa.

WILLIAM H. HANNING, M.D., Englewood; Jefferson Medical College of Thomas Jefferson University, 1935; age 72; died January 20, 1982; member OSMa and AMA.

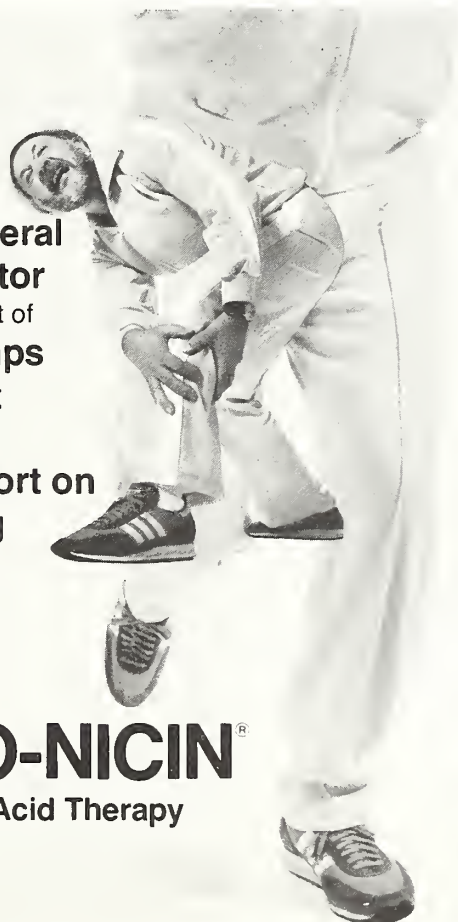
LLOYD W. JUDD, M.D., Vero Beach, Florida; Case Western Reserve University School of Medicine, 1930; age 78; died January 22, 1982; member OSMa and AMA.

J. LESTER KOBACKER, M.D., Toledo; Harvard Medical School, 1924; age 82; member OSMa and AMA.

CHARLES N. MANLEY, M.D., El Paso, Texas; University of Tennessee College of Medicine, 1934; age 71; died January 20, 1982; member OSMa and AMA.

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Thiamine HCL (B-1)	25 mg.
Riboflavin (B-2)	2 mg.
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CONTINUING EDUCATION PROGRAMS

April

ADVANCED TRAUMA LIFE SUPPORT COURSES April 23-24; Cleveland, Ohio; co-sponsored: The American College of Surgeons and the American College Emergency Physicians; 22 Category I credit hours; fee: \$250; for further information and schedules contact: Richard B. Fratianne, M.D., Cleveland Metropolitan General Hospital, 3395 Scranton Road, Cleveland, Ohio 44109, (216) 459-5627.

May

MEDICAL PROGRESS FOR THE FAMILY PHYSICIAN: May 5-6; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; 12 credit hours; fee: \$100, \$50 for physicians-in-training; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/ 444-5696.

THE DIAGNOSIS AND TREATMENT OF HEADACHES IN ADULTS AND CHILDREN: May 12; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; 6 credit hours; fee: \$60, \$30 for physicians-in-training; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

NEPHROLOGY UPDATE — 1982: May 13, 14, 15; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; 16 credit hours; fee: \$150, \$75 for physicians-in-training; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

CURRENT TOPICS IN CLINICAL MICROBIOLOGY: May 19-20; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; 12 credit hours; fee: \$120, \$60 for physicians-in-training; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

NEURO-OPHTHALMOLOGY FOR THE PRACTITIONER - 1982: May 21-22; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; 12 credit hours; fee: \$160, \$80 for physicians-in-training; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

TREATMENT OF ATHEROTHROMBOTIC DISEASES: May 26; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; 6 credit hours; fee: \$20; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

June

MINI-RESIDENCY IN OCCUPATIONAL MEDICINE: June 7 - June 25; Kettering Laboratory, University of Cincinnati College of Medicine; 97 credit hours; contact: Sidney Lerner, M.D., Department of Environmental Health, University of Cincinnati College of Medicine, 231 Bethesda Avenue, Cincinnati 45267, phone: 513/872-4043.

Artistic Licensed (continued)

painting, sculpture, photography, graphic arts, design and creative crafts.

- To hold a National Annual Exhibition of physicians' art works.

- To encourage and assist exhibitions on a local scale.

The last two goals seem to assure the first, and all seem to be met with increasing strength each year.

Since the APAA's formation, an exhibition of physician art became an important event at the American Medical Association's (AMA) Annual Meeting in Chicago, and recently, local exhibitions are also becoming more numerous.

The South Medical Association (SMA), for example, in cooperation with the APAA, now holds a physician art exhibition at its Annual Meeting, and, in fact, during last year's exhibition, two Cleveland physicians, Vijay G. Mistry, M.D., and Victor C. Laughlin, M.D., received first-place awards for their work.

Both doctors are typical of APAA's membership.

Since the APAA's formation, an exhibition of physician art became an important event at the AMA meeting.

Dr. Mistry is the newer member. Although he has only belonged to the Association for a few months, his interest in art goes back to his childhood in India, where he was encouraged in his artwork by his primary school teachers. Although he went on to become a physician — a cardiologist — his interest in art never waned. Despite the fact that he has never received any formal art training, his works have been displayed internationally — and he has captured awards at both London and Berlin exhibits.

His major works are in oil, water colors and chalk, and it was his oil

(continued on page 310)

NEW MEMBERS

ADAMS

Brian F. Griffin, Cincinnati

ASHLAND

Laszio Murray, Jr., Ashland

BELMONT

Walter W. Jones, Martins Ferry
Aristotle Peter Lekacos, Barnesville
Gene G. Stunkle, Martins Ferry
She Ling Wong, Bellaire

CLARK

David G. Monjot, Springfield

CLERMONT

Jesus C. Hontanosas, Goshen

FAIRFIELD

John E. Lloyd, Lancaster
Nalinkant A. Patel, Lancaster
Meenakshi M. Ram, Baltimore

FULTON

Anthony C. Catipay, Wauseon

GALLIA (Gallipolis unless noted)

Manuel A. Casanova
Margaret Harnish
Saied Hojat

HAMILTON

Hilda J. Canos, Cincinnati
Jan Perry Knisely, Cincinnati

HANCOCK

Mark A. Penn, Arlington

JEFFERSON

Visith Priromprinte, Steubenville

KNOX

Marcelino T. Silva, Mt. Vernon

LORAIN (Lorain unless noted)

Rosario V. Celerio
Craig J. Chapple
Harinathrao R. Dacha
Belagodu N. Kantharaj
Richard K. Lenhart, Amherst
Charles D. O'Shaughnessy

Chandralekha P. Patel, Westlake

Shailesh C. Patel, Wellington
Mario M. Sertich
Yun-Lai Sun
Kumar N. Swamy

LUCAS

Oscar T. Cassity, Toledo

MERCER (Celina unless noted)

Thangaraj Amaran
Leo A. Escobedo
Farouk Jaara
Ramesh Singla
Truman F. Soudah
Nazih J. Yacoub, Ater

MIAMI

Anthony F. Di Giannantonio, Troy
Barbara Bremen Harbor, Troy

MONTGOMERY (Dayton unless noted)

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Frank Mannarino
David F. Mitchell
Stephen L. Newman

MUSKINGUM

Joseph C. Eichel, Zanesville
Thomas E. Rojewski, Zanesville

PORTAGE

Zia-Ur-Ra Khan, Ravenna

SENECA

Philip D. Latham, Tiffin

SUMMIT (Akron unless noted)

Robert W. Kaminski
Mohamed K. Katirji
David C. Kazmierski, Cuyahoga

Falls

Paul T. Pennza
Paul T. Rogers
Tariq Saleem, Cuyahoga Falls

Artistic licensed (continued)

painting "The Return" that took first-place honors in its class at the South Medical Association show.

Victor C. Laughlin, M.D., on the other hand, has been an APAA member for nearly 40 years, and served as the Association's president from 1975 to 1976. A practicing urologist, he paints in what spare time he can find. Although his work is largely in crafts and acrylics, it was his mixed media picture "Desert Fantasy" that received the first-place ribbon in its class at the recent SMA exhibit.

There are many Ohio physicians who belong to the APAA, and who exhibit their artwork at both the AMA and SMA Annual Meeting. Be sure to look for them if you attend — and, perhaps soon, you'll also be able to catch their work at an OSMA Annual Meeting.

However, if you're a physician artist who is not yet a member of the APAA, and would like further information on the group or a membership application, please contact:

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Treasurer, A.P.A.A.,
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THE BELLEVUE HOSPITAL
BELLEVUE, OHIO 44811

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GROUP PRACTICE IN NORTHERN OHIO has opening for general surgeon - board eligible - willing to do small amount of general practice. Small community near large metropolitan areas. Reply to Box No. 915, c/o Ohio State Medical Journal, 600 S. High Street, Columbus, Ohio 43215.

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In order to promote retention in Ohio of physicians who trained in the State, **The Journal**, in cooperation with the OSMA Department of Field Service, offers classified advertising listings at no charge to physicians-in-training desiring to practice in Ohio. Persons eligible for this service must be graduates of Ohio medical schools and/or persons who are completing an internship or residency program at an Ohio institution. They must also be currently in a medical training program or in the United States Armed Forces (or some other U.S. government service).

All classified ads will be printed anonymously by use of box numbers in a special classified ad section of **The Journal**. Replies to the ads will be channeled through the Department of Field Service, which will assist in the location process. (Replies are otherwise confidential.) Ads will be printed as frequently as space permits. (See previous issues of **The Journal** for additional listings.)

PLACEMENT SERVICE ADS



INTERNIST: With subspecialty of pulmonary medicine wants to practice in community of 15,000-100,000 people in a setting that is rural with metropolitan ties or suburban metropolitan. Eligible for specialty board exam in 1982 and available for practice July 1982. Contact Box P-84 c/o Ohio State Medical Journal.

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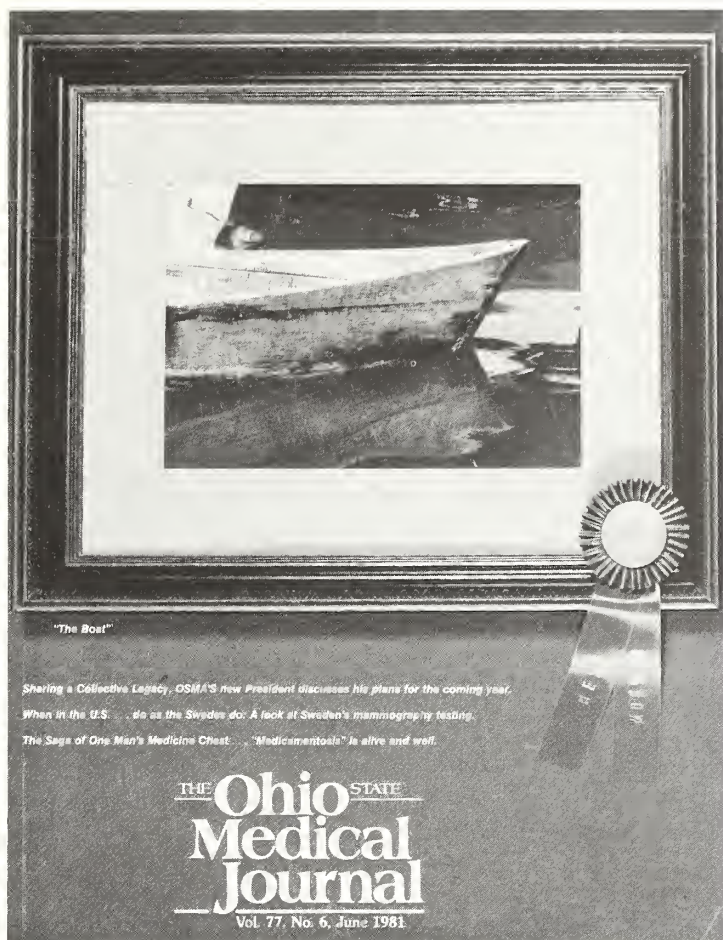
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UROLOGIST: Available July 1980. Interested in solo or group practice anywhere in Ohio. Eligible for specialty board examination May 1980. Contact Box P-53 c/o Ohio State Medical Journal.

The 1982

Ohio State Medical Journal

Photographic Exhibit



The Ohio State Medical Journal is sponsoring its fifth annual photographic exhibit and competition. The 1982 competition is open to both physicians and spouses. Persons submitting winning entries will receive awards at the 1982 Annual Meeting, Dayton, where the entries will be displayed.

Photographs may be entered in two divisions: Black and White, and Color. Each division has two categories: General and Scientific.

Entries must be in print form (8" x 10" or 11" x 14") in size) and mounted on print board, or otherwise for ease of display on a peg board. Photographs placed under glass will not be accepted. All entries submitted must be previously unpublished, and right to publish the photograph must be given to the Journal at the time the photograph is entered in the exhibit.

An OSMA member or spouse may submit as many entries as he/she wishes. Each photo must be accompanied by an entry form and a \$10.00 entry fee. If mailed, please be certain photograph is securely wrapped to avoid possible damage.

ENTRY FORM

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 If Nonmember, Spouse's Name _____
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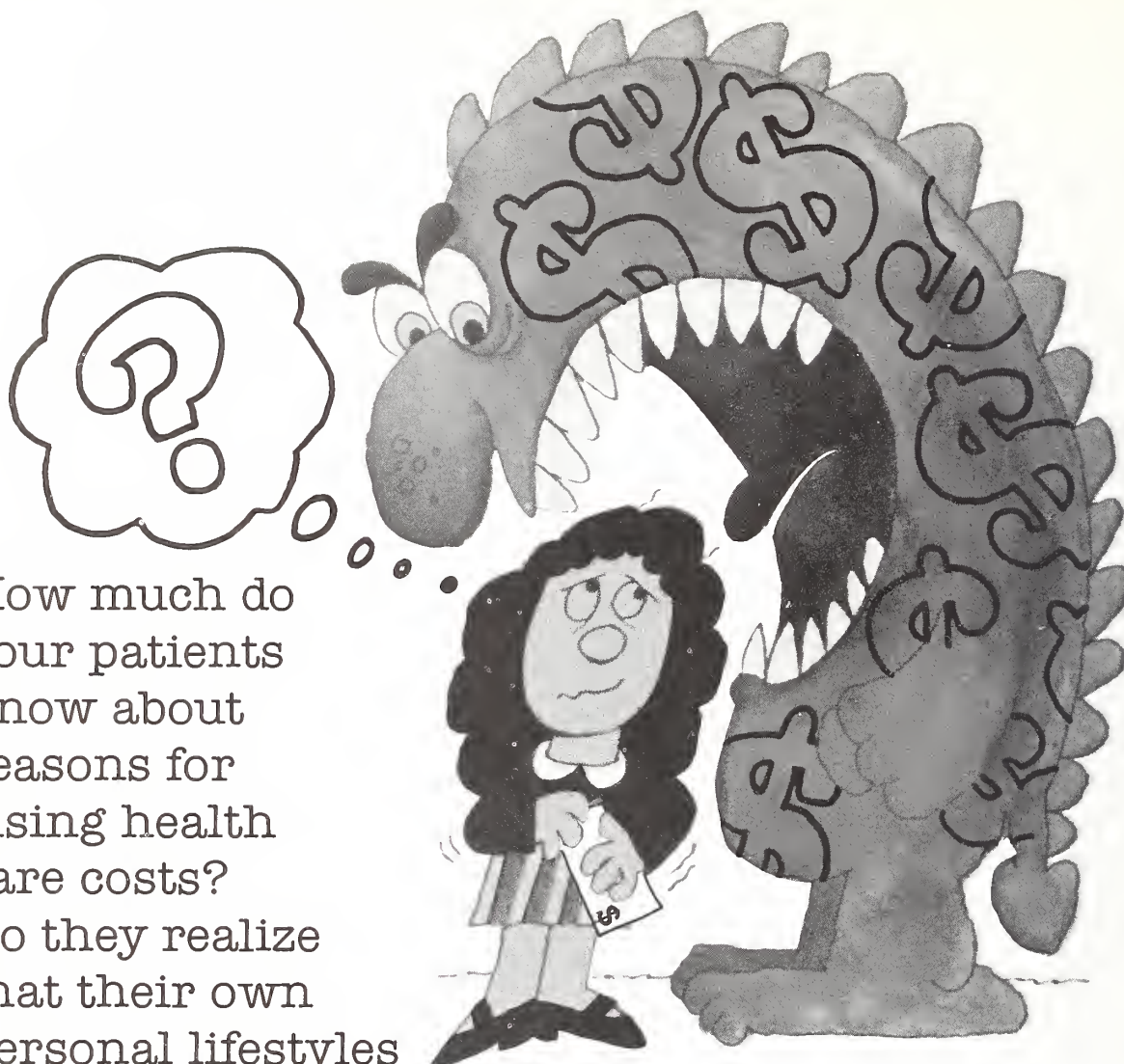
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 Speed _____ Aperture _____
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Division: ☐ B & W ☐ Color
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☐ Professional ☐ Self

Mail or hand carry the photograph, entry form and \$10 entry fee (make checks payable to The Ohio State Medical Journal) to: The Ohio State Medical Journal Photographic Exhibit, 600 S. High Street, Columbus, Ohio 43215. All entries must be received no later than April 12, 1982.

I give the *Journal* publication rights to this photograph. I certify that this photograph has not been published previously and that I will not submit it for publication elsewhere pending the judging of the photographic exhibit. Also, I certify that any person(s) pictured have given me authorization to allow publication of his/her photograph. I also understand that if my photograph is selected for a Journal cover, it may be cropped to meet printing specifications.

Signature _____



Cartoon Courtesy of ASIM

How much do your patients know about reasons for rising health care costs? Do they realize that their own personal lifestyles may be contributing to this rise?

Help them fight back!

The Ohio State Medical Association has developed a set of four posters designed to help inform your patients about their role in controlling rising health costs. The posters discuss the costs associated with smoking, alcohol, and drug abuse and a sedentary lifestyle and what your patients can do to not only help control costs, but be healthier at the same time.

Let your patients know you're concerned about rising costs and you need their help in controlling them. These colorful, informative posters are available at \$4.95 per set; 2 sets for \$8.00, and 3 sets for \$10.00.

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succeeds

in acute exacerbations of chronic bronchitis[†]

lowers the volume, clears the sputum

[†] Due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in the judgment of the physician Bactrim offers some advantage over the use of a single antimicrobial agent.

1. Rubin RH, Swartz MH. *N Engl J Med* 303:426-432, Aug 21, 1980.

2. Data on file, Medical Department, Hoffmann-La Roche Inc.

In controlled multicenter studies involving *H. influenzae* and *S. pneumoniae*, a 7-day follow-up after 14-day treatment showed the causative organisms were eliminated in 50 of 55 patients (91%).² Five patients did not return for follow-up.

During therapy, maintain adequate fluid intake. Bactrim is contraindicated during pregnancy at term and lactation, in patients hypersensitive to its components, and in infants less than two months of age.

with B.I.D. convenience... **Bactrim™ DS** (800 mg sulfamethoxazole and 160 mg trimethoprim)



Bactrim DS

(800 mg sulfamethoxazole and 160 mg trimethoprim)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination.

Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. Limited clinical information presently available on effectiveness of treatment of otitis media with Bactrim when infection is due to ampicillin-resistant *Haemophilus influenzae*. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonia. To date, this drug has been tested only in patients 9 months to 16 years of age who were immunosuppressed by cancer therapy.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term, nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBCs are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur.

During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folate metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients, cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

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Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

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Address All Correspondence, Address Change, & Reprint Request (unless otherwise noted): Executive Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215. Phone: 614/228-6971.

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1981 Subscription: \$15 per year, single copy \$2 (outside U.S. \$20 and \$3).

Send address changes to: The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second Class Postage paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by
The Lawhead Press, Inc., Athens, Ohio



SECOND OPINION

Free Air?

By Emil S. Dickstein, M.D., and William D. Loeser, M.D.

We have already documented the erosion of Medicare benefits to the deserving elderly ("Medicare Coverage in Nursing Homes — A Broken Promise," *New England Journal of Medicine*, 1981; 304:353-355. Reprinted in the *OSMA Journal*, June, 1981, Vol. 77; No. 6:349-353.) Now, we note that the flow of oxygen to elderly Medicare recipients is being restricted — at least in the case of portable or home oxygen — as zealous intermediaries misinterpret recent Medicare regulations.

The specific relevant ruling states, "Reimbursement may be made for the rental or purchase of a medically necessary, regulated portable oxygen system when prescribed by a physician for an ambulatory patient who can benefit therapeutically from use of portable oxygen. This **can** (our emphasis) be documented by **arterial** (their emphasis) blood oxygen saturation determinations."

The predicament is that the word "can" has been interpreted to mean "shall," and clerks of the intermediaries have routinely been disallowing requests for reimbursement for portable home oxygen use without arterial blood gas determinations. Requests have also been disallowed because determinations at rest have shown blood oxygen saturations above an arbitrarily chosen number, without regard to a patient's oxygen needs with minimal exertion, or to any extenuating factors.

We are not discussing borderline cases. Last year, for example, the

recent hospitalization of a patient, exhausted by a trip from car to office waiting room, included a scalene node biopsy, showing fibrotic tissue, and further study of cardiac and pulmonary function. A resting blood gas at this time was not unduly abnormal; no gases were obtained after exercise when the patient was not utilizing oxygen. The present working diagnoses are severe restrictive lung disease due to radiation fibrosis and an endocardial cushion type of cardiac defect.

Oxygen was prescribed for home use, including any activities requiring exertion. Reimbursement for this was denied on consideration and on reconsideration by the Medicare intermediary. Only after second reconsideration by the intermediary was reimbursement allowed.

We think that, even if Congress has

containment has often been relegated to intermediaries since elected officials do not like to deal directly with curtailment of benefits to their constituents. Recently, a panel of intermediaries answered questions regarding reimbursement in an educational seminar designed to aid local agencies in making decisions as to reimbursement for patients such as the one reported.

Of interest were the following guidelines:

- The carrier has ultimate responsibility for determining medical necessity prior to dispensing funds. This is not easy for use of oxygen, so all information must be received and evaluated prior to a valid determination. "Blood gases are the most readily available and the most applicable method of determining whether a patient needs supplemental

"The predicament is that the word 'can' has been interpreted to mean 'shall,' and clerks have been routinely disallowing requests for reimbursement for portable home oxygen use . . ."

found public expenditure for Medicare benefits for the elderly excessive, it is still inappropriate that their efforts for cost containment result in inequitable and, on occasion, ludicrous denial of benefits.

To complicate matters further, the actual implementation of cost

home oxygen."

- New extensive prescriptions for oxygen use are important for each period of use (eg, monthly) since prescription errors and unauthorized oxygen use could otherwise occur.

- If a claim is properly completed and all necessary information is

included and valid, a request for further information should not be necessary; however, "A claim which appears to be complete may contain insufficient or invalid information." In that case, letters may be sent requesting the same information already on file.

• For patients with cardiac impairments, "there is a great deal of controversy among physicians. . . whether or not patients in congestive failure should be given oxygen at all. . . I doubt that a patient in severe congestive failure should have portable oxygen."

When questioned about the absolute demand for arterial blood gases, the staff did state that these were not absolutely essential, in that a "note from a physician giving us some detail as to the patient's condition or what the problems are may very well suffice in the absence of blood gases."

An interesting development on this issue has resulted from a groundswell of dissatisfaction over multiple

• If an arterial blood gas is unobtainable, try giving a complete case history of the patient, including all details of pulmonary conditions and complications; the more the better.

• Always give very specific instructions for oxygen use, including amount, flow rate, frequency and duration of use, method of delivery, overall estimated period of need, etc. Never use "prn" or "as needed."

We think intermediaries are wrongly interpreting the regulations in requiring arterial oxygen determinations. We wonder if this demand for an invasive procedure goes beyond propriety in determining payment, or may even be, under some circumstances, an assault on the patient. We also wonder how many patients (such as ours) do without oxygen and suffer because of excessively strict rule interpretations. How many physicians do not resubmit claims because of the extended paperwork they have already completed?

We conclude, as have others, that the vagaries of interpretation of complex regulations by intermediaries will inevitably lead to numerous "bad calls."

Dr. Dickstein and Dr. Loeser are members of the Ohio State Medical Association and practice in Youngstown, Ohio.

Editor's Note

"Second Opinion" is a column of opinion, written by OSMA members and discussing important issues facing medicine today. The articles express the personal opinions of the authors and do not necessarily reflect official OSMA or JOURNAL policy. The JOURNAL encourages individual members to submit articles for this column. Preference will be given to short, concise articles which discuss the current issues of the day.

"We wonder how many patients (such as ours) do without oxygen and suffer because of excessively strict rule interpretations."

reimbursement denials. One oxygen supplier, with an admitted pecuniary interest, has given the following guidelines for physicians to use in claims:

• Give a specific pulmonary diagnosis, emphasizing chronicity and avoiding the use of "asthma."

• Remember that heart disease, such as severe congestive heart failure, will not be considered as benefiting from oxygen.

• Obtain all blood oxygen saturation measurements on room air.

• Remember that reimbursement goes to arterial oxygen pressures between 50 and 60 mm HG primarily; no date need be given for when or under what circumstances such determination was obtained.

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DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandro-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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NEWS

a compilation of the latest developments, reports and products of interest to physicians.

**edited by
Gina DiBlasio Cummins**

The latest health hazard

Is television proving hazardous to health?

The next warning the surgeon general may be issuing is that television may be hazardous to your health.

In a report published recently in the *New England Journal of Medicine*, studies have found that television is serving up a variety of misconceptions that run counter to healthy living.

For example, more than three quarters of all dramatic characters eat, drink or talk about food — often more than once — and 39% of the meals depicted are not even nutritious ones.

Alcohol is mentioned in 80% of the prime-time programs — and the world of soap operas seems to literally float in alcohol, with a rate of approximately six alcohol-related events per hour.

Yet, in spite of all this eating and drinking, television characters manage to stay healthy, sober and slim — which is more than can be said for 25% to 45% of the American public who remain obese. It seems, after all, the magic of television can go only so far. . .

Supreme Court splits on physician advertising issue

The American Medical Association's (AMA) seven-year battle against the Federal Trade Commission (FTC) on the issue of physician advertising, ended recently in a 4-4 tie vote before the Supreme Court.

As a consequence, the 1980 decision by the U.S. Court of Appeals in New York, upholding the FTC's order against the AMA, is left standing. The Supreme Court decision said simply: "The judgment is affirmed by an equally divided Court."

Under the FTC's order, the AMA cannot involve itself in any way with the advertising practices of physicians unless they are clearly false and deceptive. The position of the AMA has not been that dissemination of fee information and other nondeceptive information which will help enable patients to make an informed choice among competing professions is ethical, but that misleading promotional practices, described as "solicitation," are unethical.

"The AMA is disappointed by the Supreme Court decision that failed definitively to resolve the important issues raised by the FTC's attempt to regulate the medical profession," said Joseph F. Boyle, M.D., AMA Board Chairman. "This has been a long drawn-out case stretching over seven years. The AMA had hoped that the Supreme Court would decide the important issues itself. It may now be appropriate for Congress to consider the issues the Court failed to resolve and to clarify the law."

Legislation has been introduced in the Congress that would weaken the FTC's authority. In the House, 170 representatives are cosponsoring a bill that would impose a moratorium on FTC actions against state-regulated professional associations or their state and national nonprofit associations. A Senate measure reauthorizing the FTC contains provisions exempting state-regulated professions from the scope of the FTC jurisdiction.

Meanwhile, the battle rages on

The Federal Trade Commission accused a Florida medical society of trying to prevent its members from advertising information about fees and services that could help a consumer choose a doctor.

The administrative complaint was filed against the Broward County Medical Association, whose 1,500 members are a majority of the doctors in the Fort Lauderdale area.

The FTC accused the county association of trying to intimidate its

members into following "written and unwritten" ethical codes that banned the advertising of such information as a physician's fees, professional training and experience, and knowledge of languages other than English. Doctors also weren't allowed to advertise whether they accepted credit cards or Medicare reimbursements as payments in full.

To settle the complaint, the association agreed it won't suppress truthful advertising by its members.

Poetry contest announced

Physician-poets might want to consider the upcoming poetry competition, sponsored by World of Poetry, a quarterly newsletter for poets. Grand prize will be \$1,000 and other cash and merchandise awards

will total \$10,000.

Rules and official entry forms are available from the World of Poetry, 2431 Stockton Blvd., Dept. E, Sacramento, Calif. 95817.

New drug helps heart attack victims

National Institutes of Health researchers are recommending that propranolol hydrochloride (Inderal), found last year to reduce deaths after heart attack by 26 percent, be prescribed for at least three years to patients who have survived a heart attack and can tolerate the drug.

Tests, conducted by the National Heart, Lung and Blood Institute, were discontinued nine months ahead of schedule because results revealing the benefits of the drug were considered unequivocal.

Propranolol hydrochloride is one of a class of drugs known as beta blockers that prevent certain nerve impulses from stimulating the heart, arteries and lungs. As a result, the drug tends to reduce the heart rate and the force of heart muscle contraction, thereby decreasing the heart's workload and need for oxygen and reducing blood pressure. Because of these actions, propranolol hydrochloride has been found effective in certain patients in treating hypertension and in reducing the frequency and intensity of chest pains from angina pectoris.

Skip the nip before bed . . .

The traditional glass of elderberry wine taken at bedtime to promote sleep, could have just the opposite effect.

The same goes for any other alcoholic beverage consumed before bedtime, according to Charles E. Becker, M.D., San Francisco General Medical Center, in a recent issue of the *Journal of the American Medical Association*.

Dr. Becker says that alcohol consumption can disrupt the normal sleep cycle as well as intensify existing sleep problems. In addition, it can lead to further dependence on alcohol or on sleeping pills.

Meetings

May

1982 American College of Sports Medicine Annual Meeting; May 26-29; Minneapolis Auditorium and Convention Hall, Minneapolis, Minnesota. Over 350 scientific papers will be presented. Featured speaker is Dr. George A. Bray from the University of Southern California. For more information write: ACSM, 1440 Monroe St., Madison, Wi. 53706.

June

Interventional Radiology: A Comprehensive Course. June 4-5; Johns Hopkins Medical Institutions, Baltimore, Maryland. 16 hours Category I credit. For further information, contact: Program Coordinator, Continuing Education, the Johns Hopkins University, 720 Rutland Avenue, Turner 22, Baltimore, Md. 21205.

12th Annual Emergency Medical Care Seminar; June 8-10, 1982; Executive West Motel, Louisville, Ky. 14 credit hours, Category I. For further information, contact: Kentucky Medical Association, 3532 Ephraim McDowell Dr., Louisville, Ky. 40205.

Managing Limited Health Resources: A Workshop; June 21-23, 1982; Harvard School of Public Health, Boston, Ma. Designed to enhance analytic skills and assist decision-makers with strategies for managing limited health resources. For further information, contact: Office of Continuing Education, Harvard School of Public Health, 677 Huntington Ave., Boston, Ma. 02115.

6th Joint Scientific Meeting of Korean Medical Association of America and Korean Medical Association. For further information, contact: The Korean Medical Association of America, 800 MacArthur Blvd., Suite 24, Munster, Indiana 46321.

Stimulant medications may cause tic disorder in children

Some children who take stimulant medications prescribed for hyperactivity are at risk for developing a severe tic disorder known as Gilles de la Tourette's syndrome, says Thomas L. Rowe, M.D., University of South Florida College of Medicine, Tampa, in a recent issue of the *Journal of the American Medical Association*.

Tourette's syndrome is a neuropsychiatric disorder that appears in children from age 4 to 18 years. It is characterized by persistent motor tics and repeated vocal tics.

As many as 500,000 children in the United States are taking stimulant medications for attention disorders. One in 1,500 — more than 300 children — may be particularly vulnerable to stimulant-induced Tourette's syndrome, either because of a genetic predisposition to the disorder

or because their hyperactive behavior is actually an early symptom of Tourette's syndrome, says Dr. Rowe.

He warns that treatment with stimulants can elicit tic symptoms in vulnerable children or worsen existing symptoms into a full-blown case of Tourette's syndrome, which may not be reversible even after the drug is discontinued.

Dr. Rowe speculates that the widespread use of stimulant medications may be increasing the incidence of Tourette's syndrome. Consequently, he advises that children with hyperactive or attention disorder symptoms need to be evaluated carefully for existing tics, Tourette's syndrome and for a family history of these conditions before a decision is made about beginning stimulant therapy.



Agency Reference

To find the PICO agent(s) in your area, consult the listing below.

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A Visit with an English GP

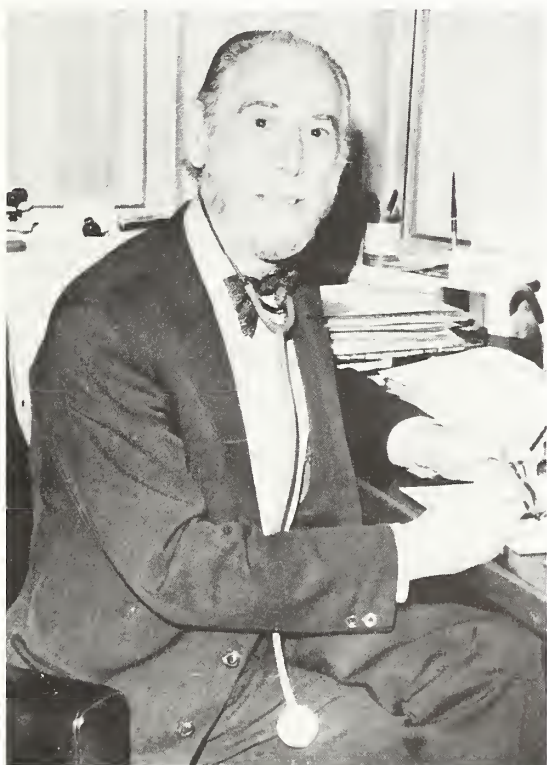
By Gordon S. Walbroehl, M.D.

During a recent visit to Great Britain, I spent an afternoon with one of our English colleagues, Dr. Phillip Hopkins, a family practitioner who practices north of London in Hampstead Heath. His office (surgery) is attached to his home and is located directly across the street from the recently rebuilt London University Hospital.

During our visit, we naturally discussed the National Health Care

Program. Phillip presented a mixed view of the National Health Service (NHS), excellent for emergency care but inadequate for chronic problems. He confirmed reports of several years' wait for elective surgery, entrance into geriatric centers, etc. The salary program for physicians is both insufficient and amazingly complex. Phillip was kind enough to share his last quarter's "earning statement" from the NHS with me.

Each physician can decide (within reason) how many or how few patients he/she cares for each year. Each doctor receives 4.12 pounds per annum per patient in his/her area. There is a supplement of 1.3514 pounds for each patient over 65 and one of 1.6625 pounds for each patient over 75. (Phillip was amused by the fact that the supplemental fee is carried out to four decimal places.) He receives a supplementary fee of 0.2125 pounds (approximately 50 cents) per patient as he agrees to see patients after hours. Additional fees are paid for women on birth control pills and also for IUD insertions. Since Phillip has seniority (greater than 30 years'



Dr. Phillip Hopkins in his Hampstead Heath office

“Phillip presented a mixed view of the National Health Service — excellent for emergency care, inadequate for chronic problems.”

experience) he receives an additional 3,000 pounds per year.

He is allowed 4,500 pounds per year for phone, car and office expenses. However, if a family member works for him, this allowance is reduced. All this in an economy which is probably one and a half times as costly as ours. Phillip freely admits he could not survive on his health service pay alone. Approximately two thirds of his income comes from private patients —

Continued on page 329

HYPERTENSION:



METHYLDOPA? RESERPINE? INDERAL? COUNTLESS

THOUSANDS WOULD BE BETTER OFF WITH

INDERAL[®]

(PROPRANOLOL HCl) B.I.D.

The sooner, the better.

Today, INDERAL—instead of methyldopa, instead of reserpine.

INDERAL exhibits few of the disturbing side effects of methyldopa and reserpine. Sedation, depression, and impotence are rare.* Tolerance is not likely to occur, as it frequently does with methyldopa. For the vast majority of patients—INDERAL means a step toward improving the quality of life. (INDERAL should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.)*

INDERAL blocks beta-receptor sites *in the heart* to reduce heart rate and cardiac output—reducing cardiac work load—sparing an overburdened heart.

Hypertensive hearts can rest easy with INDERAL.

For many—it is ideal, first-step therapy.

INDERAL—the sooner, the better for hypertension—a leading risk factor in coronary heart disease.¹

Please see following page
for Brief Summary of
Prescribing Information.



THE MOST WIDELY PRESCRIBED BETA BLOCKER IN THE WORLD

INDERAL® (PROPRANOLOL HCl) B.I.D. FOR HYPERTENSION

BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)
INDERAL® BRAND OF propranolol hydrochloride A beta-adrenergic blocking agent

BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

CONTRAINDICATIONS

INDERAL is contraindicated in: 1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE. Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta-blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. INDERAL acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by INDERAL's negative inotropic effect. The effects of INDERAL and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during INDERAL therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) If cardiac failure continues, despite adequate digitalization and diuretic therapy, INDERAL therapy should be immediately withdrawn. b) If tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuance of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS DURING ANESTHESIA with agents that require catecholamine release for maintenance of adequate cardiac function, beta blockade will impair the desired inotropic effect. Therefore, INDERAL should be titrated carefully when administered for arrhythmias occurring during anesthesia.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, INDERAL should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since INDERAL is a competitive inhibitor of beta receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA. Because of its beta-adrenergic blocking activity, INDERAL may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY. The safe use of INDERAL in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit.

Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of INDERAL may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Miscellaneous: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

ORAL

DOSEAGE AND ADMINISTRATION

HYPERTENSION. Dosage must be individualized. The usual initial dosage is 40 mg INDERAL twice daily, whether used alone or added to a diuretic. Dosage may be increased gradually until adequate blood pressure is achieved. The usual dosage is 160 to 480 mg per day. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

While twice-daily dosing is effective and can maintain a reduction in blood pressure throughout the day, some patients, especially when lower doses are used, may experience a modest rise in blood pressure toward the end of the 12 hour dosing interval. This can be evaluated by measuring blood pressure near the end of the dosing interval to determine whether satisfactory control is being maintained throughout the day. If control is not adequate, a larger dose, or 3 times daily therapy may achieve better control.

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

INTRAVENOUS

The intravenous administration of INDERAL has not been evaluated adequately in the management of hypertensive emergencies.

OVERDOSAGE OR EXAGGERATED RESPONSE

IN THE EVENT OF OVERDOSAGE OR EXAGGERATED RESPONSE, THE FOLLOWING MEASURES SHOULD BE EMPLOYED:

BRADYCARDIA—ADMINISTER ATROPINE (0.25 to 1.0 mg) IF THERE IS NO RESPONSE TO VAGAL BLOCKADE.

ADMINISTER ISOPROTERENOL CAUTIOUSLY.

CARDIAC FAILURE—DIGITALIZATION AND DIURETICS.

HYPOTENSION—VASOPRESSORS, e.g., LEVATERENOL OR EPINEPHRINE (THERE IS EVIDENCE THAT EPINEPHRINE IS THE DRUG OF CHOICE).

BRONCHOSPASM—ADMINISTER ISOPROTERENOL AND AMINOPHYLLINE.

HOW SUPPLIED

INDERAL (propranolol hydrochloride)

TABLETS
No. 461—Each scored tablet contains 10 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 462—Each scored tablet contains 20 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 464—Each scored tablet contains 40 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 468—Each scored tablet contains 80 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

INJECTABLE

No. 3265—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10.

Reference: 1. Freis, E. D. Hypertension (Suppl. II) 3:230 (Nov-Dec) 1981.

7997/482

Ayerst

AYERST LABORATORIES
New York, N.Y. 10017

people from another area who pay to see him rather than their own "free" area physician.

After lunch we made a couple of house calls together. Both were to patients within his area, which in this populated suburb is less than one square mile. The first patient was a 60-year-old man with high blood pressure. His family was out of town so Phillip went primarily to check on him and to administer a flu shot. The next patient was a woman in her eighties recovering from a recent myocardial infarction. The patient had not been admitted to a hospital as Phillip thought she would do as well at home with her family — her daughter was an RN and Phillip checked on the patient daily.

He went on to mention that he often keeps his patients with uncomplicated

myocardial infarctions at home, provided there is a supportive family. Of the subset whom he has kept at home, Phillip claims not one patient

"He went on to mention that he often keeps his patients with uncomplicated myocardial infarctions at home."

has died; whereas he estimates approximately 20% of the hospitalized patients have died, but of course this has included the more complicated

cases.

Phillip's typical day reflects a reasonable schedule: morning surgery (office hours), lunch break from 1:00-4:00 PM to make house calls, hospital visits, etc., then late afternoon surgery (4:00-7:00 PM). Saturday mornings he often meets with students from the medical school for several hours.

Comparing our two countries — lifestyles, and respective medical systems — proved to us that each system has its pros and cons and we each parted with a better understanding of the other's system.

Gordon S. Walbroehl, M.D., Dayton, is Assistant Professor, Department of Family Practice, Wright State University, and is author of "Medicine on the High Seas" which appeared in the February Journal.

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The Media Tamer

By Karen S. Edwards



Dr. O'Leary addresses members of the Cincinnati Academy of Medicine on crisis communication.

It could have happened at any hospital — to any physician. But that day last March, the Presidential limousine braked sharply outside the emergency doors at George Washington Hospital in Washington, D.C.

"In a matter of seconds, our world was thrust into drama," says Dennis O'Leary, M.D.

Dr. O'Leary is the physician credited with "The Taming of the Press," during the attempt on President Reagan's life last spring. In Cincinnati, recently, he spoke to members of the Academy of Medicine on the importance of communications in times of crisis, recounting the events that led him before the tough, elite White House Press Corps, and subsequently, before the nation itself.

"As I remember it, it was a cold,

dank, boring day. I was in a committee meeting which was about to end," he recalls — and it did end, rather abruptly.

The Presidential "hot line," installed when Richard Nixon was President, rang — letting the hospital know the motorcade was on its way, and that three people had been shot.

"No one mentioned the President," Dr. O'Leary says, but 40 seconds later, he arrived.

"Reports that the President left the limousine and came in on his own are accurate," Dr. O'Leary says. "Usually our people are there the minute an ambulance arrives, but a large, black limousine, flying an American flag, proved to be a little intimidating to our staff."

It was the only break in protocol, however. From that point on, things

moved so smoothly and swiftly "they were almost surreal," he recalls.

Unnecessary patients and personnel were escorted out of the area by the Secret Service, and once the surgery had been successfully completed, the President was ushered to a private room which, in six hours and 15 minutes became a proper Presidential suite — complete with bulletproof glass in the windows and Oriental rugs on the floor.

However, it was the President's vital communications link, which not only made the biggest impression at the hospital, but touched off the greatest problem as well.

"Within 15 minutes of the President's arrival," Dr. O'Leary recounts, "the Secret Service had set up its security command center. Within one hour, enough phone lines

were installed to enable the President to talk to anyone in the world."

But there was no one to talk to the press. Press secretary, Matthew Brady, had been one of the afternoon's victims, and was a patient himself at George Washington. The hospital public relations staff was doing what it could to help the media set up a command post of its own across the street — but obviously, someone in authority had to come forward to talk to them.

The question was "who"? An ad hoc committee comprised of senior White House officials and hospital

"I didn't feel nervous going in. I knew . . . I was going to provide the reporters a lot of detail, and I knew the advantages were mine."

staff was hastily formed, and it was the committee who decided the spokesperson should be a physician.

"They reasoned that a physician could field the technical questions better and White House officials felt a physician would be more credible to the public."

When names were suggested, Dr. O'Leary's came up naturally.

"Although I'm an internist, some of my best friends are surgeons," Dr. O'Leary jokes, and it had been Dr. O'Leary's friendship with six of the surgeons working on the President that had enabled him to provide progress reports to officials throughout the surgery. As one of the administrative heads of the hospital, he certainly had the necessary credentials to serve as a spokesman — and he had one other qualification. He was the son of a newsman. He got the job.

"The briefing before the press conference was orderly. They asked if I wished to prepare a written statement, but I refused. In situations like this, people need to be talked to. I knew a

high degree of risk was involved in appearing as spokesman. I accepted the fact that mistakes would be made — and they were." But only small, technical mistakes — the amount of blood lost, the location of the bullet to the heart.

"I didn't feel nervous going in. I knew ahead of time that I was going to provide the reporters with a lot of detail — and I really felt all the advantages were mine."

He reasoned that, after all, these reporters were not doctors — and were not even science writers.

"I anticipated repetitive, simple questions. I saw no one asking anything tough."

But just in case someone did, he had some friendly, albeit cynical, advice from White House official Lynn Nofsinger. "Just because someone asks you a question doesn't mean you have to answer it," he had been told.

"My other advantage was that I had good news," Dr. O'Leary says, "and

just the fact that I had news and they had none, put me in a win-win situation."

However, the second press conference was another story.

"By this time, the press corps had had a chance to check their medical books and call their medical experts. The questions posed in this conference were different, more mischievous. They would test me — ask the same question in different ways to catch me in an untruth. I learned that I had to think ahead of them — where are they going with this question?"

He realized that maintaining his credibility was all-important, and when a report appeared in the *N.Y. Times* that threatened his credibility, he knew he had to take them on.

"Besides, taking on the *N.Y. Times* is a once-in-a-life opportunity," he jokes.

He did it by selecting one reporter (in this case, one from the *Washington Post* whom he felt had done a superb

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reporting job), and gave her his side of the story, refuting what had been written in the *Times*.

"You have to make a careful selection of a reporter — one you feel you can trust, and who will do a good job for you. The same way a person selects a physician."

With his credibility reestablished, his dealings with the press quickly fell into a routine.

"I would write the copy, and Reagan's personal physician, Dan Rugey, would edit it. There was a definite division of responsibility. The hospital was responsible for making clinically accurate statements, and the White House would decide the amount of detail to be given out."

Dr. O'Leary digresses on this point.

"The public's right to know has to be carefully weighed against the patient's right of privacy. How much information is really in the public interest? After all, a patient does not stop being a patient just because he's also a prominent figure.

But he realized that speculation could not be permitted. Straight facts had to be given to the public.

"We tried to use an undramatic tone. We realized this was not the time or place to embellish."

After the press conference, the media was given the opportunity to call if they had further questions.

"The public's right to know has to be carefully weighed against the patient's right of privacy."

"I learned to talk to the wire services first, since other papers pick up their information from them. Then I would talk to the *N.Y. Times*, the *Washington Post*, the radio — and the TV stations, in that order."

Dr. O'Leary admits that, being camera-shy, he would often try to avoid the TV cameras altogether, "but they always had the last laugh. They would be out there every night, waiting for me to go home."

The only part of the experience he regrets is not capitalizing on the opportunity to "show off" the state of the art today.

"It may sound cruel, but the President picked the right era to be shot. He benefited from the state of the art today, and we missed the opportunity to present this to the American public as an example of how far medicine has come."

But the crisis did leave Dr. O'Leary — and the other physicians involved — with an increased respect for the media and those who work in it.

"Journalism is a responsible profession," he concludes, "in times of crisis, you learn that your counterpart in another profession — the journalist — can be a very helpful person to know."

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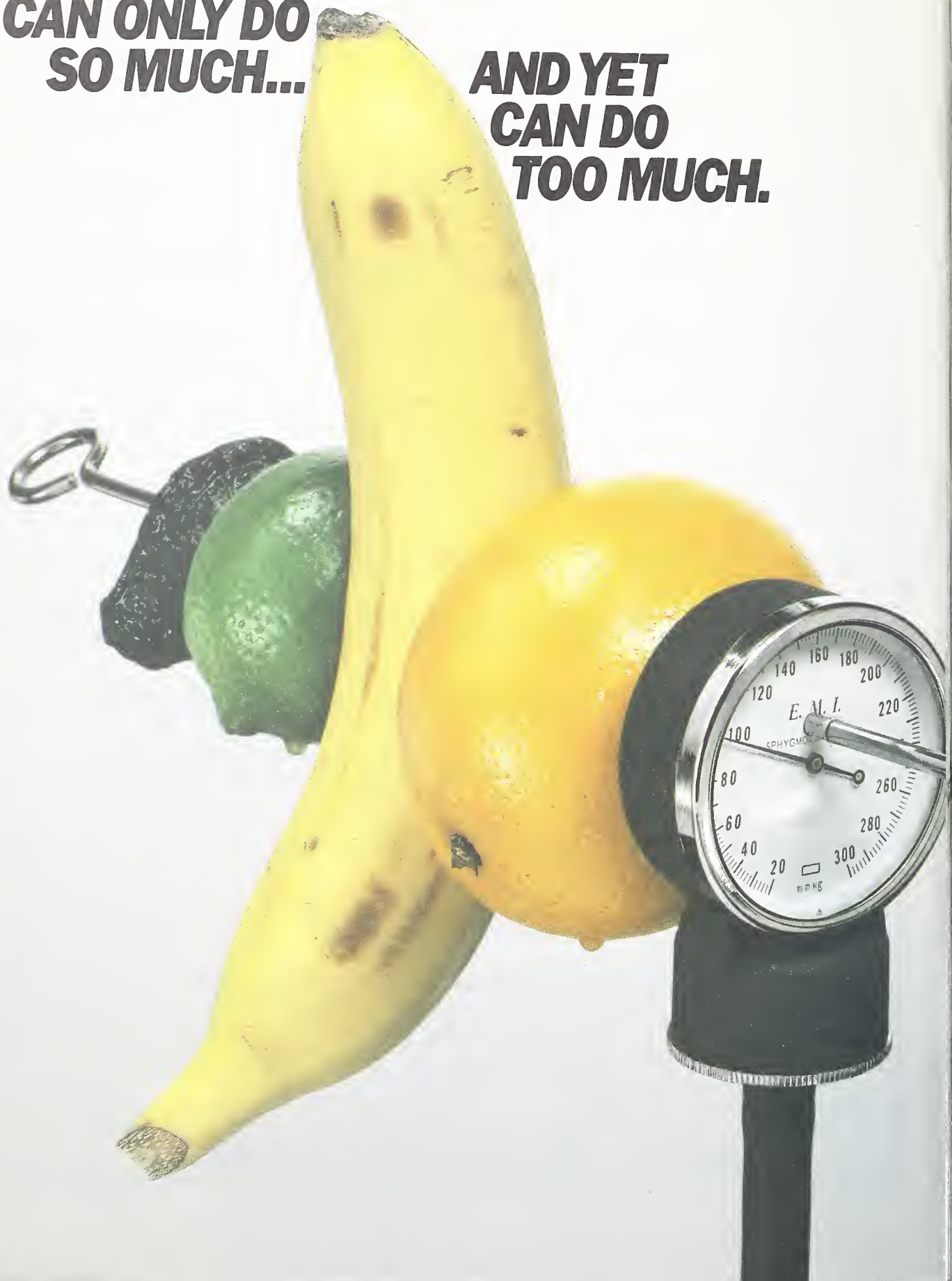
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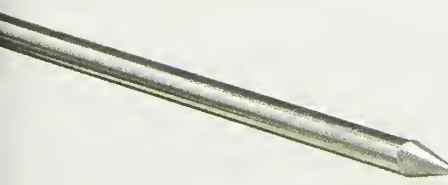
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	Hydrochlorothiazide	25 mg

WARNING: This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

DESCRIPTION: IINDERIDE combines two antihypertensive agents: INDERAL (propranolol hydrochloride), a beta-adrenergic blocking agent, and hydrochlorothiazide, a thiazide diuretic-antihypertensive.

INDICATION: IINDERIDE is indicated in the management of hypertension. (See boxed warning.)

CONTRAINDICATIONS: Propranolol hydrochloride (INDERAL®): Propranolol hydrochloride is contraindicated in 1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS: Propranolol hydrochloride (INDERAL®): **CARDIAC FAILURE:** Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) If cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn, b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in re-starting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

USE IN PREGNANCY: Propranolol hydrochloride (INDERAL®): The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

Hydrochlorothiazide: Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers: Thiazides appear in breast milk. If the use of the drug is deemed essential, the patient should stop nursing.

PRECAUTIONS: Propranolol hydrochloride (INDERAL®): Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncope attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause are: dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements such as foods with a high potassium content.

Any chloride deficit is generally mild, and usually does not require specific treatment except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

ADVERSE REACTIONS: Propranolol hydrochloride (INDERAL®): **Cardiovascular** bradycardia, congestive heart failure; intensification of AV block, hypotension, paresthesia of hands; arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy; visual disturbances; hallucinations, an acute reversible syndrome characterized by disorientation to time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometric tests.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea,

constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Miscellaneous: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

Hydrochlorothiazide: anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

Central Nervous System: dizziness, vertigo, paresthesias, headache, xanthopsia.

Hematologic: leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular: orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: purpura, photosensitivity, rash, urticaria, necrotizing angitis (vasculitis, cutaneous vasculitis), fever, respiratory distress including pneumonitis, anaphylactic reactions.

Other: hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

DOSEAGE AND ADMINISTRATION: The dosage must be determined by individual titration (see boxed warning).

Hydrochlorothiazide is usually given at a dose of 50 to 100 mg per day. The initial dose of propranolol is 40 mg twice daily and it may be increased gradually until optimum blood pressure control is achieved. The usual effective dose is 160 to 480 mg per day.

One to two IINDERIDE tablets twice daily can be used to administer up to 320 mg of propranolol and 100 mg of hydrochlorothiazide. For doses of propranolol greater than 320 mg, the combination products are not appropriate because their use would lead to an excessive dose of the thiazide component.

When necessary, another antihypertensive agent may be added gradually beginning with 50 percent of the usual recommended starting dose to avoid an excessive fall in blood pressure.

OVERDOSAGE OR EXAGGERATED RESPONSE: The propranolol hydrochloride (INDERAL) component may cause bradycardia, cardiac failure, hypotension, or bronchospasm.

The hydrochlorothiazide component can be expected to cause diuresis. Lethargy of varying degree may appear and may progress to coma within a few hours, with minimal depression of respiration and cardiovascular function, and in the absence of significant serum electrolyte changes or dehydration. The mechanism of central nervous system depression with thiazide overdosage is unknown. Gastrointestinal irritation and hypermotility can occur, temporary elevation of BUN has been reported, and serum electrolyte changes could occur, especially in patients with impairment of renal function.

TREATMENT: The following measures should be employed. **GENERAL:**—If ingestion is, or may have been, recent, evacuate gastric contents taking care to prevent pulmonary aspiration. **BRADYCARDIA:**—Administer atropine (0.25 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously. **CARDIAC FAILURE:**—Digitalization and diuretics. **HYPOTENSION:**—Vasopressors, e.g., levaterenol or epinephrine. **BRONCHOSPASM:**—Administer isoproterenol and aminophylline. **STUPOR OR COMA:**—Administer supportive therapy as clinically warranted. **GASTROINTESTINAL EFFECTS:**—Though usually of short duration, these may require symptomatic treatment. **ABNORMALITIES IN BUN AND/OR SERUM ELECTROLYTES:**—Monitor serum electrolyte levels and renal function; institute supportive measures as required individually to maintain hydration, electrolyte balance, respiration, and cardiovascular-renal function.

HOW SUPPLIED: No. 474—Each IINDERIDE®-40/25 tablet contains 40 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 476—Each IINDERIDE®-80/25 tablet contains 80 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100.

References: 1. Veterans Administration Cooperative Study Group on Antihypertensive Agents. *JAMA* 237:2303 (May 23) 1977. 2. Bravo, E.L., Tarazi, R.C., and Dustan, H.P. *N Engl J Med* 292:66 (Jan 9) 1975. 3. Hollifield, J.W., and Slaton, P.E. *Acta Med Scand* [Suppl] 647:67, 1981. 4. Holland, O.B., Nixon, J.V., and Kuhnert, L. *Am J Med* 70:762 (Apr) 1981.

Personality Styles and Antidepressants

By Gregory G. Young, M.D.

This report deals with the results of a study of 145 depressed patients consecutively treated in private practice on an office basis. These acutely depressed patients were between 19 and 76 years of age. All patients met the RDC Criteria for Major Depressive Disorder. Assessment of treatment efforts was carried out by the Hamilton

Depression Rating Scale. Twelve specific personalities are described as well as their particular stressors. This study records individual personality response to different antidepressants and dosages. It concludes with the finding that certain medications are superior to others in individual situations and records these.

Depression is a most common problem in general practice and is the most prevalent of the major psychiatric disorders. It has been estimated that up to 70% of prescriptions for tricyclic antidepressants are issued by family practitioners or internists.¹ There is often much confusion as to what the term depression means. It has been thought of variously as a symptom, syndrome, reaction and disease.

Depression is a feeling of sadness and may range from a mild lack of concern for usual interests to a despair beyond all hope. In mild depression the person is quiet, complains of lack of energy, is pessimistic and is easily discouraged. In more severe depression the person experiences poor appetite, weight loss, sleep disturbances, a lack of pleasure,

feelings of worthlessness and even suicidal thoughts. It might be said that the greater the number of symptoms and the more intense the symptoms, the more severe the depression. This paper will deal primarily with major depression. The understanding of major depression has been greatly facilitated by the recognition that there are unipolar depressions (a single or recurrent episode of depression) and bipolar depressions (where there is a history of manic episodes and depressive episodes).

The reason a person becomes depressed is directly related to the person's personality. There are some nonspecific experiences that produce sadness and depression in all of us. Examples of these would be our reaction to the death of a mate, child,

parent, or close friend. There are other more frequently encountered occurrences which would provoke varying levels of depression in certain but not all of us. This susceptibility depends on the particular personality style of the person. The physician who knows his patient, his patient's personality, and who is aware of the probable stresses, is in the best position to prescribe antidepressant medication. The antidepressant drugs have been available for about 20 years and a significant and definite problem exists in the selection of drug and dosage for the particular depressed patient. There have been many efforts to identify clinical, diagnostic, and biological approaches that will predict antidepressant response.² A most significant element to be considered in

the choice of drug and dosage is the basic personality style that each person possesses.³ In my experience each of the personality styles is particularly reactive to a type and therapeutic level of antidepressant.

Subjects and Methods

This is a report of the results of a study of 145 depressed patients consecutively treated in my private practice on an office basis between December 1, 1979, and May 31, 1981. These acutely depressed patients were between 19 and 76 years of age. Sixty percent were females and 40% were males. All met RDC Criteria for Major Depressive Disorder.⁴ The duration of dysphoric features prior to inclusion in this treatment series was at least three weeks. Patients were treated for an average of 11 weeks. Frequency of visits was once a week but if necessary the patients were seen more often. Patients were changed to another antidepressant medication if: (a) there was no symptomatic improvement; (b) their level of depression continued to increase; or (c) they experienced symptomatic aggravation after an initial period of improvement. Change took place only after the maximum dosage level had been reached or if side effects were such that change was necessary.

Patients usually were assigned to the antidepressant that the author empirically felt would be of most benefit. Frequently, however, they were maintained on the antidepressant that had been prescribed by the referring physician, usually with an increase in dosage level. Assessment of treatment was carried out by the Hamilton Depressive Scale.⁵ All patients included in this report had initial scores of 20 or greater when initially examined. They were considered to be no longer depressed when they were clinically improved and had a score of seven or less. This report focuses upon the personality style (as determined clinically and delineated by response to both YOU Personality Inventory and Written Personality Analysis), usual

Table 1

Antidepressant response related to personality styles

PERSONALITY STYLE	NUMBER OF PATIENTS*	ANTIDEPRESSANTS	RESPONSE**
Perceptive	10	Doxepin	9
	4	Amitriptyline	2
	2	Amoxapine	0
	2	Imipramine	0
	1	Desipramine	0
Persistent	6	Imipramine	5
	4	Trimipramine	3
	4	Amitriptyline	1
	2	Amoxapine	0
	1	Doxepin	0
Accomplishing	6	Amoxapine	5
	3	Imipramine	2
	3	Trimipramine	2
	2	Amitriptyline	1
	5	Imipramine	4
Sensitive	4	Trimipramine	3
	2	Doxepin	1
	2	Amitriptyline	1
	2	Amoxapine	1
	5	Amoxapine	4
Anticipating	5	Nortriptyline	4
	2	Phenelzine	2
	2	Imipramine	1
	2	Amitriptyline	1
	4	Amitriptyline	4
Influencing	4	Nortriptyline	3
	2	Imipramine	0
	2	Amoxapine	0
	1	Doxepin	1
	4	Desipramine	4
Determined	2	Nortriptyline	0
	2	Doxepin	0
	2	Amoxapine	0
	5	Nortriptyline	4
	4	Amitriptyline	3
Conscientious	1	Imipramine	0
	1	Doxepin	0
	1	Amoxapine	0
	4	Doxepin	0
	2	Amitriptyline	0
Patient	1	Amoxapine	0
	2	Imipramine	0
	1	Nortriptyline	4
	3	Desipramine	3
	1	Amoxapine	0
Adaptable	1	Amitriptyline	0
	4	Desipramine	4
	2	Amitriptyline	0
	1	Amoxapine	0
	1	Doxepin	0
Ambitious	2	Desipramine	2
	2	Nortriptyline	2
	1	Amoxapine	0
	1	Doxepin	0
	2	Desipramine	2
Idealistic	2	Nortriptyline	2
	1	Amoxapine	0
	1	Doxepin	0
	1	Doxepin	0
Total	145		

*Patients who did not benefit from the initially prescribed antidepressant after three to six weeks' therapy at maximum dose were changed to another antidepressant. No patient underwent more than one change. The total number of patients changed was 44 (30%).

**Active treatment maintained until symptom remission in 86.2% of patients. The average duration of treatment was 11 weeks. 13.8% either prematurely withdrew from the treatment program or were psychiatrically hospitalized. One-year follow-up on 89 of the patients who completed their course of treatment indicated that 81 (91%) had maintained improvement. They are no longer in treatment. Eight (9%) of the patients have reentered treatment.

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Brief Summary. Consult the package literature for prescribing information.

Indications and Usage: Cecilor® (cefactor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cecilor.

Contraindication: Cecilor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cecilor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefactor occurs, the drug should be discontinued, and if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefactor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics in hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition. It should be recognized that a positive Coombs test may be due to the drug.

Cecilor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cecilor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistix® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip USP, Lilly).

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefactor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Cecilor.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthritis and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cecilor® (cefactor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain: Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician:

Hepatic: Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematologic: Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal: Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cecilor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

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8. Principles and Practice of Infectious Diseases edited by G.L. Mandell, R.G. Douglas, Jr., and J.E. Bennett, p. 487. New York: John Wiley & Sons, 1979.

Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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precipitating factors, and response to particular antidepressant medication. The dosage level of medication usually correlated with symptom severity, patient response, and side effects encountered. This report will not comment upon the various types of concomitant psychotherapeutic intervention used in conjunction with medication (although it is the impression that a combination of effective psychotherapy and pharmacotherapy is superior to pharmacotherapy alone).⁶ The paper also will not discuss the Dexamethasone Suppression Test⁷ results in this study (however, at the outset it might be mentioned that the results do not correlate with particular personality styles), nor the measured tricyclic plasma levels (although there probably was a correlation both with the dosage level of the antidepressant and personality style of the patient).

Personality, Specific Stress, and Antidepressant of Choice

Each and every person has an identifiable personality style. This is inherited from one parent only, and persists throughout life. Personality styles are identified as dynamic combinations of the person's attitudes, modes of thoughts, feelings, impulses, strivings, actions, and responses to opportunity and stress. The following is a description of each personality style, its particular vulnerability, and empirical suggestions concerning the antidepressant of choice.

The *perceptive personality* tends to wear his emotions on his sleeve when he discusses his depression. He is able to shed tears and obviously solicit sympathy and understanding. He is reactive to all forms of deprivation, rejection, abuse and mistreatment. *Perceptive personalities* have an abiding concern for truth, fairness, and the well-being of those near and far. He is a down-to-earth, decent, outgoing person who wants to protect his interests as well as those of others. This is a feeling person and a love person. He experiences depression with marital problems, divorce, and when the people he is trying to protect

pull away from him. *Perceptive personalities* are very outspoken with their bitterness over whatever the difficult experience. This person needs his physician to be compassionate, caring, and concerned. The antidepressant of choice is doxepin HCl (10 to 75 mg daily).

A person whose life orientation is characterized by hope, faith, and creative ability, and his being able to use his thought and imagination constructively has a *persistent personality*. His depression most often occurs when his hopes and wishes have been frustrated. This person will become depressed when a relationship ends or when his ideals, philosophies, or value systems are shattered. It is almost as if this person is the original one-to-one person. This is a genial, gentle individual who trusts mightily and whose beliefs are sometimes so rich and vibrant that others are caught up in their splendor. He is the pensioner who can't pass a charitable coin box without emptying his pockets of change, even when it means he has to miss lunch. His basic disposition, his primary orientation, is to establish a close bond with another human being. He is very devoted to and involved in his values and commitments. Depression comes when he cannot appreciate that which he has experienced in this commitment. His depression responds primarily to imipramine HCl or trimipramine maleate. The recommended dosage for both is from 50 to 250 mg daily. There is little response at dosages lower than 50 mg or above 250 mg.

A person who places much emphasis upon living with a high level of energy, who wants to impress others, and earn their approval, affection, and applause can also experience depression. He is a person who, when he meets a problem, has a tendency to try too hard to overcome it. If at first he doesn't succeed he's willing to try and try again until he exhausts himself. This person with an *accomplishing personality* looks on life with a robust appetite for doing all the things that appeal to him. He is a high energy person who has a bit of exaggeration as part of his life style. It

shows in the way he works, and in the way he plays and in what he expects to accomplish. His expectations of himself are high. However, it's his willingness to work hard and play hard and to make a maximum effort that makes him susceptible to problems. He tries to do too many things at once, diffuses his energy, and often tries to exceed his capabilities. He tries so hard but he is easily bruised by criticism. It's these expectations that eventually lead to depression. The physician's way of handling this person's expectations is so important. The person needs anything but criticism and disapproval. He needs to be supported for his high level of effort and helped to recognize when he has done his best in whatever the situation. The antidepressant that seems to be most helpful is amoxapine and the recommended dosage is from 50 to 150 mg daily. This was the personality style that, prior to availability of amoxapine, had responded best to imipramine HCl. There are fewer side effects with amoxapine.

Your sensitive patient may not make very good eye contact with you when he describes his depression. He is reflective, introspective, highly sensitive to his own mood and moments, feelings, and thoughts. He is often very reactive to that which goes on around him. He's usually a very content, serene person, happy to be alive. He feels at one with the world and one with his fellow human beings. He is a person with great humanitarian interests who would like to see a chicken in every pot and a car in every garage. He is a person who is always looking for the sensible, efficient, dependable, and purposeful solution to a problem. It's almost as if the Golden Rule was devised for and by him. It's this sensitivity of the *sensitive personality* that perhaps renders him overly reactive to the attitudes and opinions and statements of those around him. He can become overly sensitive to any criticism, any slight or even smallest abrasions of human exchange. The *sensitive*

Continued on page 344

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The #1 hemorrhoidal pad† for added external relief and gentle cleansing of fecal residue

- ☐ Soothes, cools, comforts the irritation and itch of hemorrhoids and other common anorectal disorders
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* Meeting of Am Soc Colon / Rectal Surgeons, May 1980.

** Based on total prescriptions filled for hemorrhoidal preparations during the first three quarters of 1981. The National Prescription Audit, IMS America Ltd, Sept 1981.

† 1981 data from leading marketing research organization.

PD-85-JA-0867-P-1 (2-82)

ANUSOL-HC[®] Suppositories / ANUSOL-HC[®] Cream

Before prescribing, please see full prescribing information. A Brief Summary follows:

Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in external and internal hemorrhoids, proctitis, papillitis, cryptitis, and fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol[®] Suppositories or Ointment.

CONTRAINDICATIONS

Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

WARNINGS

The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

PRECAUTIONS

General

Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.

Pregnancy

See "WARNINGS"

Pediatric Use

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

DOSAGE AND ADMINISTRATION

Anusol-HC Suppositories—Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

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Table 2
Antidepressant response with change in antidepressant

PERSONALITY STYLE	NUMBER OF NONBENEFITING PATIENTS FROM TABLE 1	ANTIDEPRESSANT INITIAL TO CHOICE*	RESPONSE**
Perceptive	2	Amitriptyline	2
	2	Amoxapine	2
	2	Imipramine	1
Persistent	2	Amitriptyline	2
	2	Amoxapine	1
	1	Doxepin	1
Accomplishing	1	Amitriptyline	1
Sensitive	1	Doxepin	1
	1	Amitriptyline	1
	1	Amoxapine	1
Anticipating	1	Imipramine	0
	1	Amitriptyline	1
Influencing	2	Imipramine	1
	2	Amoxapine	2
Determined	2	Nortriptyline	2
	2	Doxepin	2
	2	Amoxapine	2
Conscientious	1	Imipramine	1
	1	Amoxapine	1
	1	Doxepin	1
Patient	2	Amitriptyline	1
	1	Amoxapine	1
	2	Imipramine	1
	1	Nortriptyline	1
Adaptable	1	Amoxapine	1
	1	Amitriptyline	1
Ambitious	2	Amitriptyline	2
	1	Amoxapine	1
	1	Doxepin	1
Idealistic	1	Amoxapine	1
	1	Doxepin	1
Total	44		

*Patients were switched to the antidepressant of choice for the patient's personality style.

**Active treatment maintained until symptom remission. Thirty-eight (86.3%) improved to the extent that they were no longer clinically depressed and had a score of seven or less on the Hamilton Depressive Scale.

personality notes, according to Murphy's Law, that "If anything can go wrong, it will." He benefits so much from a physician whom he can trust, one who recognizes that he has a need for privacy, that he is very loyal, and that he is perhaps hypersensitive. The antidepressants that help this person most are imipramine HC1 or trimipramine maleate. The preferred dosage is 25 to 100 mg daily.

The person who wants to be genuine and authentic in everything

he does and who is fully attuned to the future is the *anticipating personality*. It is often this ability to plan, arrange, and anticipate that if carried too far can produce depression. This person becomes caught up in worrying. He in fact might call himself a "worrywart." When he worries he feels less adequate to the task. He supposes that his personal resources are inferior and that he will do poorly. He has problems with change. He has a tendency to minimize himself. The attitude that helps this person best is

one that emphasizes a one-step-at-a-time approach. It's so important that he give himself credit for his efforts. He benefits both from amoxapine (at a level of 100 to 300 mg daily depending on severity of depression) and nortriptyline HC1 (at the 75 to 150 mg daily level). This is the one personality style who responds well to the MAO inhibitors (phenelzine sulfate - 30 to 60 mg daily).

The person who is organized and emphasizes quality, neatness, and cleanliness most probably has an

influencing personality. He's a perfectionist who stresses being in control of conversations and nicely says, "Let's do it my way." He pursues perfection in many ways including health and physical fitness. This person can become depressed when his strivings to be in charge are frustrated. He finds it difficult to accept opinions of others. He never has a small problem and his depression becomes a colossal crisis. This personality benefits so much from the physician's listening and helping him look at choices and alternatives. He so often sees only one path. The antidepressants that help him most include amitriptyline HC1 and nortriptyline HC1, both at a 25 to 100 mg dosage.

The *determined personality* is a persuasive, unassuming and low-keyed person who can disarm you with his indirect approach. He has a knack for putting together strategy that can make a difficult situation productive. This person tries to avoid

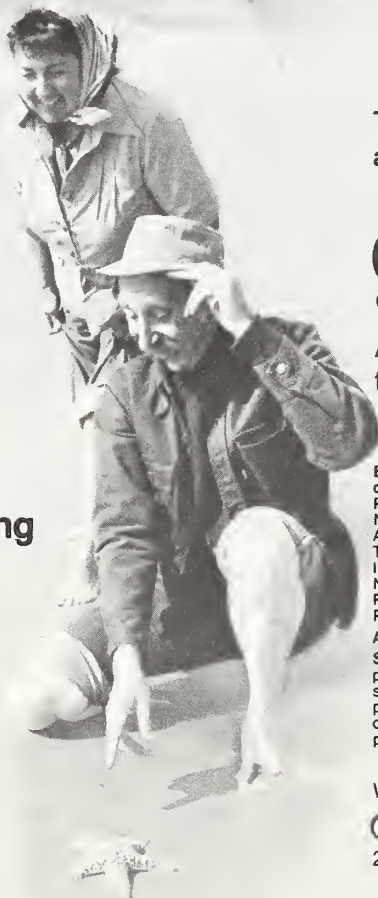
head-on confrontations and hard-nosed stalemates but can end up in them. He has an urge to be right and places much emphasis upon respect. When he does not obtain this respect he feels embarrassed. So often others get in his way because he is not open about his position. When his course is repetitively blocked, when he is embarrassed, and when he is unable to know where he stands, depression is inevitable. It's necessary that the physician show him respect and help him consider the possibility that right is relative and that compromise is reasonable. It's to be remembered that unless directly asked he will not voluntarily reveal the extent of his depression. He benefits from desimipramine HC1 and the preferred dosage level is 50 to 150 mg daily.

The *conscientious personality* is a rather careful, deliberate person who shows much attention to details. He will bring more than enough information to his physician. He tells you all of this because he wants to

make sure that he does not leave out anything that might be significant. You will be impressed by his tendency to doubt, question and search for information. He becomes depressed when his quest for certainty is thwarted and when he cannot consider any positive possibilities. He considers so many alternatives that he cannot consider any action. He benefits so much from a physician who has a positive approach and emphasizes how important it is for him to think happy thoughts and consider the positive. He will find relief from amitriptyline HC1 or nortriptyline at a 100 to 200 mg daily dosage level. He often does not experience symptom remission until this level is attained.

When you recognize how much patience, tolerance, forbearance and endurance a person has, you likely are dealing with a person who has a *patient personality*. He is generous in giving of himself and he goes about it in a calm and unruffled way. He's

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SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

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INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

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responsible and responsive, understanding of others, and straightforward in manner. He finds it easy to give and help and make the world a secure place for others. However, there are times when he feels frustrated because of the demands made upon him. When he feels that he perhaps has not given or tolerated enough he experiences depression. This person benefits so much from the physician who allows and encourages him to ask for himself, to have his own needs, strivings, and wishes. It's very helpful when he can recognize that there are times he expects others to read his mind. The antidepressant that helps him the most is doxepin HC1. The dosage level is from 50 to 150 mg daily.

The *adaptable personality* makes friends easily, blends in well into almost any environment, and can react openly in most situations. This person is able to share whatever the environment offers, accepts others as they are, and delights in the ideas and

opinions that others find so easy to share with him. He is alert and attuned to his environment. He is a person who is able to make friends on many levels. He experiences depression, however, when he stops utilizing his greatest strength — his ability to communicate. He also becomes depressed when he is reluctant to test his own capabilities. The physician who knows this patient's *adaptable personality* already has come a long way toward helping him become what he can be. When encouraged to communicate and test his capability he becomes more free and independent and able to do so. The antidepressant that proves most helpful for him is desipramine HC1 and the dosage level is 50 to 150 mg daily.

When winning, success, and victory are all-important it's probable that the person has an *ambitious personality*. When setbacks come and he does not win, or when he is not busy, depression is likely. It's almost as if he

is only at home when he is challenging, competing, and winning. He so wants to be highly rated by all around him, thus being very vulnerable to feelings of depression. It's difficult to recognize reasons for his depression because he often displaces concern from one problem to another. He wants instant cure and considers his depression as getting in his way. The medication of choice for this person is desipramine HC1 and the recommended dose is from 25 to 75 mg daily.

The person who shows a tremendous concern for independence and individualism and has his own standards probably has an *idealistic personality* style. His image and ideas impose a set of guidelines that he resolutely adheres to. Most often he sets standards for himself and the world around him. When he is unable to adhere to these, or especially when he finds it difficult to accept his needs and helplessness and dependency, he can become depressed. At such time

Table 3
Antidepressant response percentage as related to personality styles

PERSONALITY STYLES	Amitriptyline	Amoxapine	Desipramine	Doxepin	Imipramine	Nortriptyline	Phenelzine	Trimipramine
PERCEPTIVE	50	0	0	0	90	—	—	—
PERSISTENT	25	0	—	83	0	—	—	75
ACCOMPLISHING	50	83	—	66	—	—	—	66
SENSITIVE	50	50	0	80	50	—	—	75
ANTICIPATING	50	80	—	50	—	80	100	—
INFLUENCING	100	—	—	—	100	75	—	—
DETERMINED	—	0	100	—	0	0	—	—
CONSCIENTIOUS	75	0	—	0	0	80	—	—
PATIENT	0	0	—	0	75	0	—	—
ADAPTABLE	0	0	100	—	—	—	—	—
AMBITIOUS	0	0	100	—	0	—	—	—
IDEALISTIC	—	0	100	—	0	100	—	—

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alcoholics. Ethanol may produce many effects that together bring about nutritional deficiencies, so that alcoholism affects nutrition at many levels.¹

25,500,000 geriatric

patients. The older patient may have some disorder or socioeconomic problem that can undermine good nutrition.²

23,500,000 surgical

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References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease*, op. cit., p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, op. cit., pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med* 89 (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.



minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.

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he especially benefits from a physician who is willing to talk with him and accept him. It's so necessary that the physician introduce an awareness that the person can be even more independent once he accepts that at times he can be needy, helpless, weak, and dependent. This person is reluctant to use medication but the antidepressants that are most beneficial are both desipramine HCl and nortriptyline HCl at a 25 to 75 mg dosage level daily.

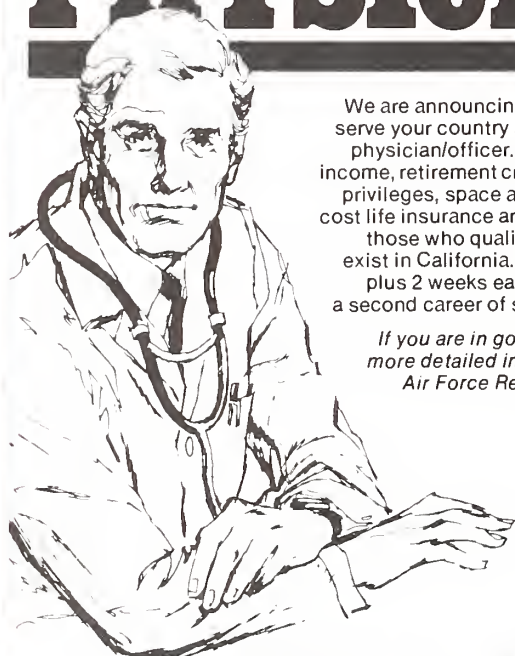
Results

Patients who are treated with the antidepressant of choice for their personality style did experience greater relief from depression (Table 1) than those treated with other antidepressants. Benefit from the antidepressant that has not proven to be effective for the particular personality style was minimal. The persons who were initially treated with a noneffective antidepressant did, however, improve when the appropriate antidepressant was initiated (Table 2). In dealing with major depression it is frequently difficult to obtain the needed clinical information concerning the precipitating stress and the person's personality at the time of the initial encounter. The selection of proper antidepressant thus is greatly influenced by the clinicians experience as well as by the data and facts available. In 101 patients (70%) the correct antidepressant was initially prescribed. With the progression of the treatment program, additional clinical material, personality testing data, and response to antidepressants prescribed, medication was changed to the antidepressant of choice when necessary. This occurred in 44 patients (30%). Antidepressant effectiveness does appear to be greater in certain of the personality styles and totally noneffective in others (Table 3).

Discussion

There has been much clinical, theoretical, and pharmacologic interest in the role of personality and personality differences in depression.⁸ However, to date this interest has not resulted in a clear relationship between personality factors, stress particular to the personality, and the choice of pharmacotherapy. It is quite

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The Physician's Sleep Glossary

Some common sleep laboratory terms

poly·som·no·graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la·ten·cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af·ter sleep on·set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to·tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.¹

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.²

re·bound in·som·nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.³

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Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, light-headedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

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possible that an awareness of genetic and developmental factors particular to each individual personality style⁶ will facilitate specific research into this important dimension. Each and every person can experience depression if the particular stress is sufficient. Certain persons have been subjected to rather intense and prolonged stress and have little opportunity to avail themselves of appropriate psychotherapy, pharmacotherapy, and/or environmental relief. These individuals, therefore, are more susceptible to occurrences of depression. They have lower self-esteem, relate more narcissistically, and are more likely to be pessimistic and negative about their existence. It is probable that a major breakthrough in the understanding and treatment of depression will occur when the relationship between genetic factors, pharmacotherapy specific to each personality style, and each personality's particular strengths and vulnerabilities is better understood.

Conclusions

The physician must recognize not only the depression but the personality of the person depressed. It is only then that the physician will be able to prescribe the antidepressant of choice in such a way that maximal benefits from the medication will be obtained. He will be in a better position to utilize tricyclic plasma levels, measures such as d-amphetamine therapeutic prediction trials, etc. He will be able to keep in mind that a therapeutically effective dosage with a high level of clinical efficacy and a low level of side effects depends much upon the personality of the patient receiving the medication. He will be better able to compare the drugs listed in this report with new antidepressant agents as they become available and to evaluate possible overlap of therapeutic effects of various classes of antidepressants. Understanding the patient and his personality affords the physician the

Man's best friend may prove to be his best medicine as well

Recent studies of relationships between animals and humans have shown that pets seem to have a positive effect on people's mental health and survival after heart attacks, reports a recent issue of the Alcohol, Drug Abuse and Mental Health News.

One study, conducted at the University of Pennsylvania, found that heart attack victims who owned pets had a much better survival rate than those patients who did not. Of the 53 patients who owned pets, only three of them had died within one year after hospitalization. Of the 39 patients who did not own pets, a little over one third had died within one year after hospitalization.

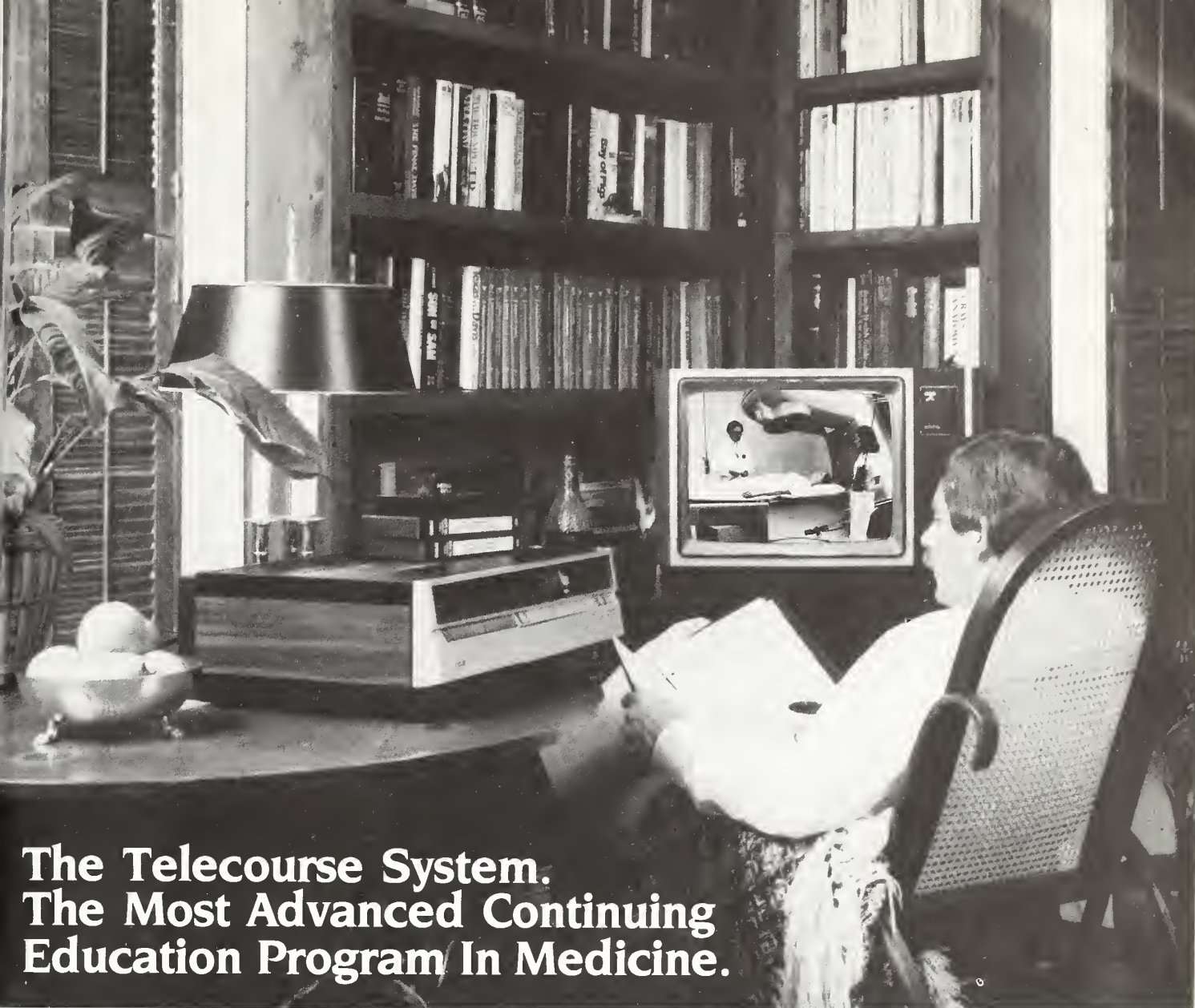
The researchers originally had assumed that dog owners were a special class unto themselves. They



reasoned that the owners' longevity benefited from exercise when walking the dogs. But they discovered that the survival rate remained significantly higher even for the owners of cats, fish and birds, who don't get walked.

Eleanor Ryder, a professor in the School of Social Work at the University of Pennsylvania, believes preliminary evidence also shows that "animal companions help alleviate depression and provide emotional sustenance and companionship.

She told of one graduate student's study of the effect of pets on elderly people who were placed in foster homes. In nine out of ten cases, the presence of pets improved the older persons' sense of self and of being needed.



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opportunity to both choose a proper antidepressant and help the person understand what is wrong, what needs to be done, and the ways that he can more likely be constructive, creative, and effective.

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CHARLES J. AMANN, M.D., Cincinnati; St. Louis University School of Medicine, 1956; age 53; died January 1, 1982; member OSMa and AMA.

JOHN T. BURNS, M.D., Anaheim, California; St. Louis University School of Medicine, 1926; age 84; died March 16, 1982; member OSMa and AMA.

ROBERT S. DEAN, M.D., Cleveland; Case Western Reserve University School of Medicine, 1919; age 88; died August 23, 1981; member OSMa and AMA.

ABE ALVIN FISHER, M.D., Canton; University of Michigan Medical School, 1925; age 84; died

November, 1981; member OSMa and AMA.

SAMUEL W. HERMAN, M.D., Winter Park, Florida; University of Cincinnati College of Medicine, 1924; age 85; died February 23, 1982; member OSMa and AMA.

MARY PATTEN HUNTER, Springfield; Albany Medical College, Union University, Albany, 1938; age 77; died November 11, 1981; member OSMa and AMA.

JULIUS KRAMER, M.D., Bristol, Indiana; Ohio State University College of Medicine, 1916; age 92; died February 16, 1982; member OSMa and AMA.

WILLIAM N. MACEY, M.D., Cleveland; Loyola University Stritch School of Medicine, Maywood, 1934; age 73; died February 28, 1982; member OSMa and AMA.

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ABRAHAM W. NELSON, M.D., Cincinnati; Case Western Reserve University School of Medicine, 1900; age 102; died May, 1980; member OSMa and AMA.

L. WARREN PAYNE, M.D., Austin, Texas; University of Texas Medical Branch, Galveston, 1929; age 76; died February 24, 1982; member OSMa and AMA.

JOHN R. PHILLIPS, M.D., Green Valley, Arizona; Medical University of South Carolina College of Medicine, Charleston, 1943; age 68; died February 10, 1982; member OSMa and AMA.

CHARLES G. POPELKA, M.D., Cleveland; University of Cincinnati College of Medicine, 1968; age 42; died March 4, 1982; member OSMa and AMA.

ARDEN G. STEELE, M.D., Loveland; Northwestern University Medical School, Chicago, 1941; age 66; died February 13, 1982; member OSMa and AMA.

DENSMORE THOMAS, M.D., West End, North Carolina; Jefferson Medical College, Thomas Jefferson University, 1937; age 75; died March 13, 1982; member OSMa and AMA.

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INDICATIONS: Cardilate (Erythrityl Tetranitrate) is intended for the prophylaxis and long-term treatment of patients with frequent or recurrent anginal pain and reduced exercise tolerance associated with angina pectoris rather than for the treatment of the acute attack of angina pectoris since its onset is somewhat slower than that of nitroglycerin.

CONTRAINDICATIONS: Idiosyncrasy to this drug.

WARNING: Data supporting the use of nitrates during the early days of the acute phase of myocardial infarction (the period during which clinical and laboratory findings are unstable) are insufficient to establish safety.

PRECAUTIONS: Intraocular pressure is increased therefore caution is required in administering to patients with glaucoma. Tolerance to this drug, and cross-tolerance to other nitrites and nitrates may occur.

ADVERSE REACTIONS: Cutaneous vasodilation with flushing. Headache is common and may be severe and persistent. Transient episodes of dizziness and weakness, as well as other signs of cerebral ischemia associated with postural hypotension, may occasionally develop. This drug can act as a physiological antagonist to norepinephrine, acetylcholine, histamine and many other agents. An occasional individ-

ual exhibits marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur even with the usual therapeutic dose. Alcohol may enhance this effect. Drug rash and/or exfoliative dermatitis may occasionally occur.

DOSE AND ADMINISTRATION

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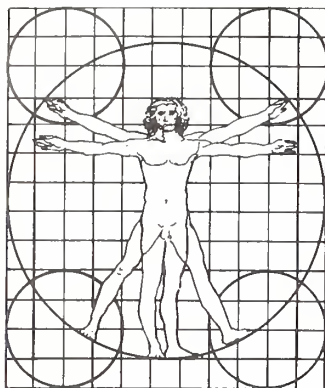
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CLINICAL & SCIENTIFIC

NEONATAL HYPOTHYROID SCREENING IN OHIO

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William B. Zipf, M.D.
John H. Ackerman, M.D.
Charles Croft, Sc.D.
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The value of early identification and treatment of inborn errors of metabolism to prevent developmental disabilities through neonatal screening programs has been well documented. Recent legislation amended the Ohio statute that required testing of all newborns for phenylketonuria (PKU) and added testing for hypothyroidism, galactosemia and homocystinuria. The blood specimen collected to detect PKU also is utilized for a radioimmunoassay determination of T₄ and thyroid stimulating hormone (TSH). Notification of parents regarding the proposed tests is required. A pilot project for neonatal hypothyroid screening recently was completed with 231,000 specimens tested from seven counties over a 39-month period. The incidence of this disorder was one in 6,300 live births and compares favorably with the reported incidence in North America of one in 5,900. Proper follow-up of positive tests by the Ohio Department of Health and the attending physicians is essential for the success of this program.

ALMOST TWO DECADES have passed since the introduction of mass screening for early identification of inborn errors of metabolism. The use of the dried blood spot from neonates to detect phenylketonuria (PKU) by Guthrie¹ was a milestone in public health toward the goal of prevention of mental retardation and other developmental disabilities. The beneficial effects of the PKU screening program have created considerable interest in utilization of the same specimen to test for other conditions where early diagnosis and treatment can prevent chronic disability.

The frequency of occurrence of neonatal hypothyroidism,² (approximately one in 5,000 births versus one in 15,000 births for PKU in Ohio)³ and the difficulty with early clinical diagnosis, placed great emphasis on its inclusion in many state screening programs. This action was reinforced by a recommendation of the American Thyroid Association⁴ for (1) the establishment and expansion of preliminary screening program for congenital hypothyroidism, and (2) combining testing for hypothyroidism with existing newborn screening

programs to improve cost effectiveness and help guarantee quality control and efficient follow-up. The Committee on Genetics⁵ of the American Academy of Pediatrics supported this recommendation noting that: "The effectiveness of testing will be diminished unless there is a comprehensive program to accommodate the separate processes of testing, patient retrieval, diagnosis and follow-up."

The first regional screening program for congenital hypothyroidism was implemented in 1974 in the Province of Quebec. Dr. Dussault and his colleagues adapted the T₄ radioimmunoassay system to filter paper blood spots already in use for PKU screening.⁶ Subsequently, Foley⁷ began measurement of cord serum thyroid stimulating hormone (TSH) concentrations using a routine serum TSH radioimmunoassay.

Further refinement of the testing procedures took place in the next few years. These technical advances have made mass screening more practical and economically sound since early diagnosis of hypothyroidism eliminates from the public budget the high cost for care and rehabilitation of those children

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Submitted March 4, 1981.

who otherwise would have been severely mentally handicapped.⁸ Current estimates of the cost in Ohio to the public and private sector for maintenance of such an individual for 30 years is \$500,000; the cost to the public sector to identify and treat that child before brain damage has occurred is approximately \$10,000. Thus, for each child identified by the program who otherwise would have been diagnosed and treated too late to prevent severe mental retardation, there is a savings of \$490,000.

Recognizing the value of such a program to the citizens of Ohio, the Department of Health, with strong support from the physicians in the state, asked the Ohio General Assembly to consider legislation mandating newborn screening for this disorder, using the same specimen presently collected for PKU detection. In July 1980, amended House Bill 1056 was passed and signed by the Governor authorizing the testing for hypothyroidism, galactosemia and homocystinuria, with an effective date of October 24, 1980. This article reviews our experience with a pilot project for neonatal hypothyroid screening in effect from August 1977, through November 1980, at the Ohio Department of Health, and describes the new statewide program implemented November 1980, as a result of this mandate.

Materials and Method

Since 1966, Ohio law has required screening of all newborns for PKU. This mass screening has been accomplished through the use of the filter paper blood spot method of collection. The pilot hypothyroidism screening program utilized this same specimen in testing 233,000 newborn infants over a 39-month period from August 1977, through November 1980. At least 24 hours after the establishment of full milk feedings, a small amount of capillary blood was collected from the newborn infants' heels and applied to filter paper cards. These cards containing the dried blood specimens were sent by first class mail to the Ohio Public Health Laboratories in Columbus. Upon arrival at the centralized state laboratories, the specimens were sorted and their suitability for testing was determined. The specimens were handled according to the scheme depicted in the figure.

Data handling and reduction were initially done by hand but now are entirely automated utilizing a unique data analysis computer program designed for the State of Ohio by Presearch, Inc. (Arlington, Virginia), and Meloy Laboratories. Raw counts from the gamma counters are automatically fed into the computer. Standard curves are generated and quality control is checked and presented for review to the laboratory technologist before values are determined. Values then are reported for each specimen and printed on a form suitable for immediate mailing. Suspicious and abnormal values are listed separately at the end of each day for appropriate follow-up as depicted in the figure. The computer also checks all incoming samples against its list of called-for repeats. If a repeat sample has not been received within two weeks, a special report is automatically generated to alert the department of a delinquent sample. This is followed up by a telephone contact with the referring physician or hospital. As is shown in the diagram, a statistical analysis is made on the results each day. The "low" T_4 value was defined according to the protocol outlined by the American Academy of Pediatrics Committee on Genetics.⁵ To take advantage of the large number of infants being tested and to overcome inherent difficulties with radioimmunoassay systems used for mass screening programs, a "floating" cut-off system is recommended by this protocol. In addition to the thyroid screening, each specimen also was tested for galactosemia, homocystinuria, and phenylketonuria.

During the 39-month pilot hypothyroidism screening program, infants born in seven Ohio counties were tested for congenital hypothyroidism. The counties included in the study were Cuyahoga, Franklin, Hamilton, Lucas, Muskingum, Stark, and Summit.

The radioimmunoassay of Meloy Laboratories, Inc., is being used for measurement of T_4 . TSH was measured by the radioimmunoassay of Nichols Institute Diagnostics (San Pedro, California). Equipment used in the assays included a Tracor Model 1285 gamma counter, a Dupont centrifuge (Sorvall Instrument Group, Model RC3), and two punch index machines (Fundamental Products).

A suspicious result is defined as being a value 1.3 S.D. below the daily mean. All suspicious results (1.3 S.D. below daily mean) require that the original sample be retested in duplicate. If this repeat value is more than 2.3 S.D. below the daily mean, a TSH test will be performed on the original sample. Following this test, the sample is reported as normal, a repeat specimen is requested, or an immediate telephone report is made to the referring physician as depicted in the figure.

A method to ensure proper medical follow-up of abnormal test results was instituted. The genetics nursing consultant at the Ohio Department of Health, Division of Maternal and Child Health, was employed to facilitate communication with the infants' physicians and to provide linkages with pediatric endocrinology consultants and the Ohio regionalized genetics program. Through this mechanism of follow-up, physicians and families may be placed in contact with other state programs such as the Bureau of Crippled Children's Services.

Results

Since the initiation of the pilot hypothyroidism screening program, over 233,000 infants born in seven Ohio counties have been screened. Among these infants, 37 cases of congenital hypothyroidism have been detected. The incidence of the disease for this group of babies is approximately one in 6,300 live births. This figure approximates the incidence of one in 5,900 found in other screening programs conducted in North America.⁵

A full range of comprehensive diagnostic and treatment services has been made available to affected infants through the follow-up mechanism employed at the Division of Maternal and Child Health. The network of pediatric endocrinologists throughout the state has ensured the availability of consultative services for referring physicians.

Discussion

House Bill 1056 amended Section 3701.501 of the Ohio Revised Code, the existing statute requiring newborn testing for PKU. It mandated the addition of testing for hypothyroidism, homocystinuria, and galactosemia, utilizing the same blood sample collected for PKU testing. The attending physician is responsible for seeing that the blood specimen is collected from each newborn child *not sooner* than 24 hours after the first protein feeding. A blood specimen from a premature infant is to be collected when the attending physician determines that such specimen collection is no longer contraindicated, but in no case shall the hypothyroid screen be delayed more than four weeks.

In addition, this legislation enabled the Director of Health to "encourage and assist in the development of programs of education, detection and treatment of genetic diseases and provide for habilitation and counseling, for persons afflicted with genetic disease, and to accept and administer grants and to carry out the functions of the law."

This law also required that parents of newborn infants be given notice regarding the proposed test to be performed. Specific rules adopted by the public health council include that each hospital of delivery shall provide the parent with printed information describing the newborn genetic, endocrine and metabolic screening programs. A special brochure detailing this information has been made available by the Ohio Department of Health.

Continued on page 365

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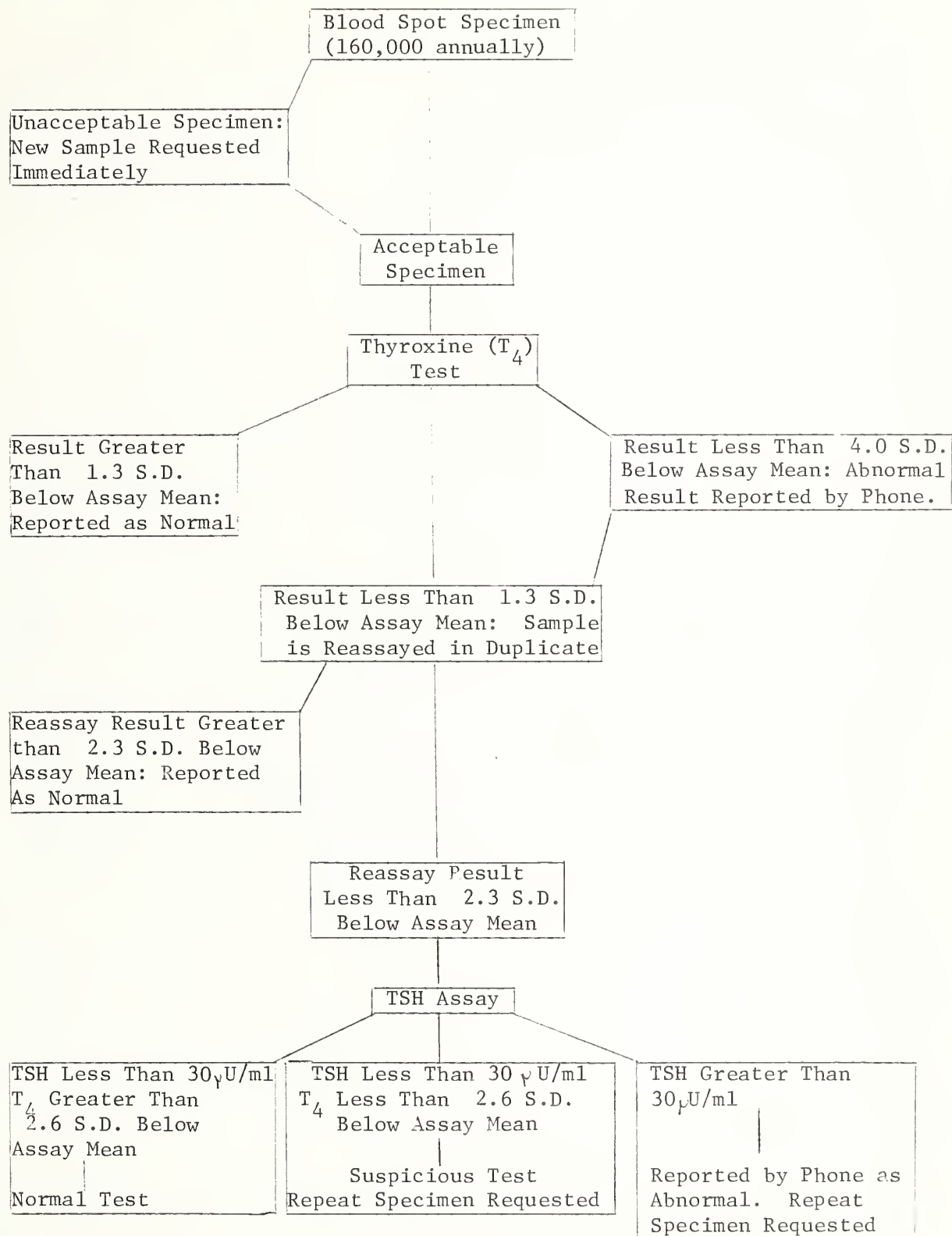
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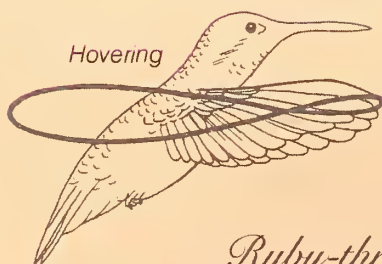
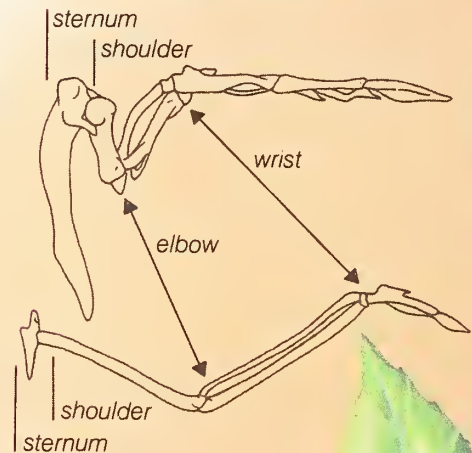
Neonatal Hypothyroid Screening in Ohio (cont.)



Continued on page 368

One of nature's most distinctive designs...

Compared with a typical bird wing (lower drawing), the "hand" portion of the hummingbird wing (upper drawing) is greatly enlarged, while the elbow and wrist are small and rigid. Maneuverability occurs only at the shoulder. This structure actually permits the hummingbird to hover and fly backwards like a helicopter.



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Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Due to isolated reports of exacerbation, use with caution in patients with porphyria.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction, changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults.* Mild and moderate anxiety disorders and symptoms, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. *Geriatric patients* 5 mg b.i.d. to q.i.d. (See Precautions.)

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ment of Health to every hospital having a licensed maternity unit. When a birth does not occur in a hospital, the attending physician or midwife shall provide the parent with printed information. The Ohio Department of Health is responsible for providing this information to the physician or midwife.

When a birth does not occur in a hospital, the attending physician or midwife is responsible for seeing that the blood specimen is collected for appropriate testing for these disorders. The specimen is to be collected within the first two weeks of life, but not sooner than 24 hours after the first protein feeding. If there is no physician or midwife in attendance at the time of birth, the local registrar of vital statistics, when notified that such a birth has occurred, must report the occurrence of the birth to the health commissioner of the district in which the birth occurred. The health commissioner then is responsible for seeing that the blood specimen is collected and submitted for testing.

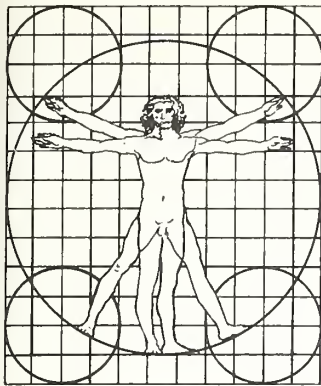
With an expected incidence of one in 5,000 to 6,000 live births, congenital hypothyroidism constitutes a major public health problem in Ohio. Prognosis and effective management are dependent upon early diagnosis. Within the context of a mass statewide screening program, this prompt identification of affected infants appears to occur efficiently. The use of a centralized screening laboratory also helps to maximize uniformity of testing procedures as well as provide a large volume of samples which is essential if a statistical definition of the low T_4 value is to be used.

Further information and assistance regarding this program may be obtained by contacting:

Ohio Department of Health
Charles Croft, Sc.D.
Leonard Porter, M.Sc.
Division of Health Laboratories
614-466-2280
Ms. Kathryn Peppe, R.N., M.S.
Division of Maternal & Child Health
614-466-8932
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CLINICAL & SCIENTIFIC

FOLLOW-UP EVALUATION AND THERAPY AFTER A POSITIVE NEONATAL THYROID SCREEN

William B. Zipf, M.D.
Antoinette P. Eaton, M.D.
Dennis M. Doody, M.D.
John H. Ackerman, M.D.

The addition of thyroid testing as part of the newborn infant screening program to detect errors of metabolism is a major asset to the physician caring for children. As with any screening program this test will identify infants at risk, but the actual diagnosis and the institution of appropriate therapy will depend on further action by the physician. Appropriate studies should be performed to determine the exact diagnosis and to make decisions regarding treatment. To prevent the mental retardation caused by congenital hypothyroidism, these decisions should be made within the first few months of the infant's life.

CONGENITAL HYPOTHYROIDISM has many etiologies including thyroid agenesis or dysgenesis, dysgonadogenesis as a result of a thyroid enzyme defect, a defect in the fetal hypothalamic-pituitary-thyroid axis, fetal in-utero exposure to maternally ingested antithyroid drugs, maternal antithyroid antibodies, or maternal iodine deficiency (see Table 1). Severe retardation of both physical and mental development are possible consequences to the infant of untreated neonatal hypothyroidism. Although treatment begun during the later childhood years can repair physical growth abnormalities, delaying onset of treatment beyond the first few months of life can result in permanent and severe mental retardation. Previous studies have shown that four times as many children with congenital hypothyroidism whose onset of treatment began after three months of age have IQs less than 85, than similarly diagnosed children whose treatment began before three months of age.¹ Recent experience with infants diagnosed from neonatal screening programs has found normal IQs in all diagnosed and treated children.^{2,3} Most of these infants, whose congenital hypothyroidism was diagnosed before one month of age, began their treatment before six weeks of age. Even with this relatively early diagnosis, treatment and normal IQ scores, these children had an increased incidence of abnormal, soft neurologic signs as compared to unaffected children. This observation underscores the importance of early identification and follow-up of infants suspected of having hypothyroidism.^{3,4}

Since clinical signs often are subtle, the early diagnosis of

hypothyroidism by this method alone is difficult. Only 10% to 15% of infants with neonatal hypothyroidism might be identified before eight to twelve weeks of age using clinical signs alone.^{5,6} However, with the advent of newborn screening for congenital hypothyroidism, this diagnosis usually can be made within two to six weeks of birth and treatment can be instituted quickly. A description of the newborn thyroid screening program administered through the State of Ohio Public Health Laboratories is presented in the preceding article entitled Neonatal Hypothyroid Screening in Ohio.

Although over 99.9% of all infants tested will have normal thyroid function, the physician potentially can be faced with a number of different types of abnormal results. These include:

- (A) Very low T_4 (4.0 S.D. below the mean) and borderline or high TSH ($> 30\mu$ U/ml)
- (B) Low T_4 (2.6 S.D. below the mean) and borderline or high TSH ($> 30\mu$ U/ml)
- (C) Low T_4 (2.6 S.D. below the mean) and normal TSH ($< 30\mu$ U/ml)
- (D) Very low T_4 (4.0 S.D. below the mean) and normal TSH ($< 30\mu$ U/ml)

Infants in groups A and B should be given the presumptive diagnosis of primary hypothyroidism, have an immediate evaluation, and then begun on thyroid hormone replacement as soon as possible. If the evaluation does not confirm the diagnosis, the treatment can be discontinued.

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Dr. Ackerman, Columbus, Clinical Professor of Preventive Medicine, The Ohio State University, and Director, Ohio Department of Health.

Submitted March 4, 1981.

TABLE 1

POSSIBLE CAUSES OF NEONATAL HYPOTHYROIDISM

Fetal Abnormalities
Primary Hypothyroidism
Congenital thyroid hypoplasia, agenesis, or ectopia
Hereditary inborn error of thyroid hormone secretion
Secondary Hypothyroidism
Isolated TSH deficiency
Panhypopituitarism
Tertiary Hypothyroidism
Hypothalamic dysplasia
Hypothalamic-pituitary-thyroid axis immaturity (transient)
Maternal Abnormalities (May cause transient or permanent hypothyroidism in the infant)
Autoimmune Thyroid Disease
Antithyroid Drugs and I ¹³¹
Iodine Deficiency
Iodine Excess

The evaluation should include a careful history related to the presence or absence of familial thyroid problems, maternal thyroid disease, antithyroid drugs used during pregnancy, or maternal exposure to iodine or radiation. The mother also should be questioned to determine if she has observed in the infant any of the classical symptoms of hypothyroidism. The physician should note the presence or absence of any of the classical signs of neonatal thyroid deficiency (see Table 2).

Follow-up laboratory evaluation of an infant with a presumptive diagnosis of congenital hypothyroidism is necessary to confirm the diagnosis, and selected studies often are helpful in management of these patients. These tests are listed in Table 3. All infants with a presumptive positive diagnosis should have serum obtained by venipuncture for a routine T₄ and TSH assay. A thyroid binding globulin (TBG) assay or T₃ resin uptake also should be obtained to rule out congenital TBG deficiency as the cause of the hypothyroxemia, since infants with this condition have normal amounts of active-unbound thyroxine and do not need treatment. (If an elevated serum TSH has been confirmed by routine methods, this test may not be necessary.) In cases with a maternal history of autoimmune thyroid disease, antimicrosomal antibodies and antithyroglobulin antibodies should be measured in the infant and mother.

Radiologic evaluation of skeletal maturation also may be helpful in the initial evaluation. A skeletal age determination is the only indicator presently available to assess the severity of the hypothyroid condition on fetal development and may have some prognostic usefulness regarding the later occurrence of mild motor or neurologic sequelae.³ This information may be beneficial to the physician both for immediate counseling purposes and later, if neurologic or learning problems appear during the child's subsequent development. A marked delay in skeletal age also is further support for the diagnosis of thyroid

TABLE 3

FOLLOW-UP LABORATORY EVALUATION OF AN INFANT WITH PRESUMPTIVE HYPOTHYROIDISM

Necessary

T₄ concentration (serum by venipuncture)
TSH concentration (serum by venipuncture)
TBG or T₃ Resin Uptake

Possibly Helpful

Skeletal age determination
Thyroid Scan
Antimicrosomal and Antithyroglobulin antibodies T₃ RIA

hormone deficiency, and the results of this study sometimes are more rapidly available to the physician than most other studies.

Radioisotope studies are indicated in certain instances. A thyroid scan with either a small dose of 99M pertechnetate of I¹²³ is useful in the evaluation of the infant with both suspected hypothyroidism and a neck mass, since diagnosis of the mass as a thyroid goiter rules out other causes of congenital neck masses. Visualization of a normally placed thyroid gland in the infant of a mother with a positive history of autoimmune thyroid disease, iodine deficiency, or ingestion of antithyroid medication would suggest the possibility that normal thyroid function might return within a few weeks.^{7,8,9} In these rare instances an infant may not need immediate thyroid treatment if the infant is asymptomatic and close follow-up can be assured.¹⁰

Infants whose thyroid screening results show low T₄ values, but normal TSH concentrations (groups C and D) may have TBG deficiency, normal but delayed thyroid function (transient hypothyroidism), secondary hypothyroidism (TSH deficiency), and a few might have primary hypothyroidism with a delayed rise in TSH.^{7,11} A follow-up evaluation with a complete history, physical examination, and laboratory analysis of serum obtained by venipuncture for T₄, TSH and TBG (or T₃ resin uptake) should be obtained as soon as possible. If the infant has no symptoms or clinical signs of hypothyroidism and if laboratory results will be available within one or two weeks, treatment may be withheld until the diagnosis is confirmed.

Special consideration should be given to the infant suspected of having TSH deficiency. These infants will have a normal TSH but low or very low T₄ concentrations, and often have many symptoms or signs of hypothyroidism. The infant with TSH deficiency as the cause of the low T₄ also may have other pituitary hormone deficiencies. The absence of growth hormone, ACTH, and/or antidiuretic hormone (ADH), places the infant at risk for developing severe hypoglycemia and cardiovascular insufficiency. Full thyroxine replacement, in face of these other hormone deficiencies, may suddenly unmask these symptoms if they are not already present and should not be done until an adequate evaluation is performed and necessary additional treatment is instituted under close supervision by the physician. Secondary hypothyroidism is much rarer than primary; it only occurs in about one out of every 100,000 live births.⁵

The premature or very ill newborn infant may also have a low T₄ and normal TSH concentration on the initial and repeat thyroid screen. In almost all instances these infants eventually develop normal thyroid function within two to six weeks, but they present a diagnostic problem for the physician.¹¹ Extensive evaluation of all these infants usually is unnecessary. The cost/benefit ratio of these evaluations may be very low. However, these infants are at risk for having permanent abnormal thyroid function. As the various thyroid screening programs in this and other countries develop more experience with this

TABLE 2

CLINICAL SIGNS AND SYMPTOMS OF NEONATAL THYROID DEFICIENCY

Prolonged gestation	Weak cry
Large size at birth	Feeding problems
Prolonged jaundice	Constipation
Hypothermia	Poor weight gain
Mottling of the skin	Hypotonia
Umbilical hernia	Large tongue
Large posterior fontanelle	Dry skin

group, it may be possible in the future to assess the infant's thyroid function more definitively with the screen alone. Until that time, the premature infant with a low T_4 and normal TSH pattern on the repeat test should be observed closely for development of signs of hypothyroidism and have repeat analysis of his thyroid function before eight to twelve weeks of age to document development of normal thyroid hormone secretion. If the infant begins to develop multiple signs of hypothyroidism or develops an elevated TSH level, a thyroid scan should be obtained and the infant should be begun on thyroid replacement. If the scan demonstrates the presence of normally positioned thyroid tissue, thyroid hormone treatment may be withdrawn for a brief period of time at one to two years of age to determine if a normal and adequate thyroid gland is present.

The most recent recommendations for thyroid replacement for the child with hypothyroidism suggest oral administration of L-thyroxin at a dose of 25-60 mcg/day or 8-10 mcg/kg/day, during the first six months, and 50-75 mcg/day or 6-8 mcg/kg/day from six to twelve months of age.¹² The suggested dose beyond one year is 2-4 mcg/kg/day until adulthood. An alternative dose schedule is 100 mcg/m²/day for all age groups.¹² An infant with hypothyroidism and severe cardiac disease may need lower starting doses of thyroid hormone. Dose adjustments during the first months of treatment may be necessary and should be made on the basis of serum T_4 concentrations. Serum concentrations of T_4 should be maintained in the high normal range for age. Adequacy of thyroid replacement for the child should be determined by periodic evaluation of his or her growth, physical and mental development, in addition to the standard laboratory evaluations. Discrepancies in these evaluations should raise the question of compliance. During the first year of life these evaluations should take place at three-month intervals and during the second year they should be performed at six-month intervals. Yearly evaluations usually are sufficient during the remainder of childhood.

Mandatory screening for congenital hypothyroidism will allow for the rapid identification of most infants at risk for the development of the profound neurologic and mental deficiency secondary to this condition. The identification of these infants, no matter how effective, will not protect the child from the ravages of this disease. This responsibility and opportunity now rest with the medical community, the obstetrician, family physician and/or pediatrician involved in the care of the infant. In addition to being alert to the thyroid screening results, the family physician and pediatrician also must be aware

that the screening program will miss a small percentage of infants with congenital hypothyroidism; it will remain the responsibility of the physician to detect these hidden cases.

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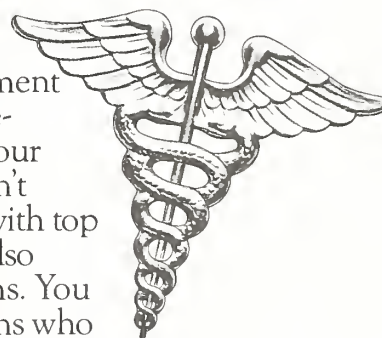
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Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Due to isolated reports of exacerbation, use with caution in patients with porphyria.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety disorders and symptoms, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. *Geriatric patients:* 5 mg b.i.d. to q.i.d. (See Precautions.)

Supplied: Librium® (chlordiazepoxide HCl/Roche) Capsules, 5 mg, 10 mg and 25 mg—bottles of 100 and 500; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25, and in boxes containing 10 strips of 10. Prescription Paks of 50. Libritabs® (chlordiazepoxide/Roche) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100 and 500. With respect to clinical activity, capsules and tablets are indistinguishable.

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Karl S. Messerrly
United Media Associates, Inc.
16 Bruce Park Avenue
Greenwich, Connecticut 06830
Telephone: 203/661-9702

Regional

The Ohio State Medical Journal
600 South High Street
Columbus, Ohio 43215
Telephone: 614/228-6971

Address All Correspondence, Address Change, & Reprint Request (unless otherwise noted): Executive Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215. Phone: 614/228-6971.

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1981 Subscription: \$15 per year, single copy \$2 (outside U.S. \$20 and \$3).

Send address changes to: The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second Class Postage paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by
The Lawhead Press, Inc., Athens, Ohio



Roche Products Inc.
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TO THE EDITOR:

Every physician should give careful consideration to the suggestion of Dr. Walter Chess in the last issue of the *OSMA Journal*, suggesting that physicians reduce their fees by 10 percent in an attempt to lower the costs of medical care.

It is difficult for me to believe that physicians, who have the highest average income of all professional people in the U.S., and who are supposedly dedicated to the prevention of disease and healing of the sick, regardless of their ability to pay, are not the leaders in an effort to reduce the exorbitant cost of medical care.

Sincerely yours,
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avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.; Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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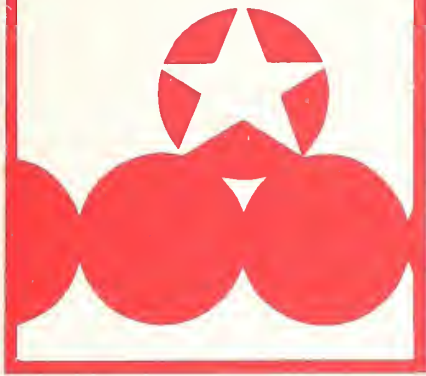
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COLLEAGUES IN THE NEWS



G. K. ADAMS, D.O., general practitioner, was elected chief of staff of Amherst Hospital medical staff, and **R. L. EVANS, D.O.**, was elected vice chief of staff.

FLAVIO AMONGERO, M.D., Cincinnati, was elected chief of the medical and dental staff of Mercy Hospital South in Fairfield. Dr. Amongero is a thoracic and vascular surgeon. **ELMER F. WAHL, M.D.**, was elected secretary.

JACK BASS, M.D., Hilliard, will continue as member of Government Affairs Committee for the National Arthritis Foundation. Dr. Bass is director of the Rheumatism Disease Service at Children's Hospital; clinical professor of pediatrics at Ohio State University; chairman of the Advisory Committee for the Ohio Arthritis Care and Education Program; and past president of the Ohio State Medical Association Rheumatology Section.

ROY BONTRAGER, M.D., was appointed by the Hocking County Commissioners as medical director of the Emergency Medical Service.

CHARLES BRANDEN, M.D., was elected president of the medical staff of Marymount Hospital, Bedford. Also elected were **JOHN MARGRETT, M.D.**, president-elect of the medical

staff and chairman of the medical council; **GARY KLEINMAN, M.D.**, secretary of the medical staff; and **WILLIAM BRUCK, M.D.**, treasurer of the medical staff.

ALFRED L. DeSANCTIS, M.D., surgeon, was elected president of the medical staff of Massillon Community Hospital. Also elected were Robert C. Erickson II, secretary-treasurer and **DONALD L. WILSON, D.D.S.**, member-at-large.

EDWARD G. DITCH, M.D., Sunset Hills, was presented a plaque and named Director Emeritus of The Farmers and Merchants Bank. Dr. Ditch has been a member of the institution's board of directors for 46 years.

OLGIERD C. GARLO, M.D., was installed as president of Tiffin Mercy Hospital's medical staff. Dr. Garlo is a general practitioner and psychiatrist. Also installed were **VIRGILIA LIM, M.D.**, internal medicine, as vice-president, and **WILLIAM C. COOK, M.D.**, obstetrics and gynecology, as secretary-treasurer.

LARRY GIBSON, M.D., Mansfield, was elected president of the medical staff of Mansfield General Hospital. Dr. Gibson is an orthopedic surgeon.

The new laboratory at St. Joseph Riverside Hospital, Warren, will be named "The **ARTHUR M. GINZLER** Laboratory" in honor of the Doctor. Dr. Ginzler was presented with a plaque which reads, "In grateful recognition of his outstanding professional and personal contributions to St. Joseph Riverside Hospital and in appreciation of his true dedication to the hospital and its patients."

BRUCE GRAHAM, M.D., Dublin, was named secretary of the board of trustees of United Church Homes,

Inc., of Upper Sandusky. Dr. Graham will serve on the executive board and chair the long-range planning committee of United Church Homes, which operates five retirement homes in Ohio and Indiana.

EMILY HESS, M.D., and **SONYA OPPENHEIMER, M.D.**, are among ten women chosen by the Enquirer as Women of the Year for 1981.

Dr. Hess is retired director of the Department of Rehabilitation of Good Samaritan Hospital, and is now in private practice. She has been a consultant on disability evaluation and pain problems, and is active in the Multiple Sclerosis Society of Cincinnati.

Dr. Oppenheimer is coordinator of the Neurological Birth Defects Program at the Cincinnati Center for Developmental Disorders. She has worked to gain state guidelines for treatment of children with spina bifida and cerebral palsy.

CARL P. HERKIMER, M.D., Toledo, was elected chief of staff of St. Luke Hospital's medical staff. Also elected were **CHARLES W. WATSON, M.D.**, Toledo, chief of staff-elect, and **DONNA A. WOODSON, M.D.**, Maumee, secretary-treasurer.

ASHER O. HOODIN, M.D., Cincinnati, was elected president of the medical staff of Jewish Hospital. Dr. Hoodin is director of urology and serves on the hospital planning committee and its board of trustees.

CONRAD JAVIER, M.D., is president, and **RALPH KOVACH, M.D.**, is president-elect of the medical staff of St. Alexis Hospital, Cleveland. Dr. Javier is a cardiologist and Dr. Kovach is an orthopedic surgeon.

H. SHEFFIELD JECK, M.D., Oxford, was honored by Hospital Care Corporation, of which Blue Cross in Southwestern Ohio is a regional office, for his contributions to the plan and

its subscribers as president of Cincinnati Region's Physician Advisory Council. Dr. Jeck has been in the practice of general surgery in Oxford for 25 years.

PAUL JONES, M.D., was reelected chairman, and **CHARLES DONLEY, M.D.**, was elected secretary of Good Samaritan Medical Center.

ALLAN KIRSNER, M.D., Toledo, was appointed chairman of the Ohio Arthritis Committee. Dr. Kirsner is director of the rheumatology progressive care unit at Flower Hospital.

ERNEST J. McCAMPBELL, M.D., Cleveland, was presented with an award inducting him into the Tuskegee Institute Athletic Hall of Fame, for his outstanding contribution to the athletic program during his college days at Tuskegee.

JAMES B. McMILLAN, M.D., pathologist, Oberlin, was appointed to the new position of hospital medical director of St. Joseph Hospital. Dr. McMillan recently was installed as president of the Lorain County Medical Society.

FRANK R. MOORE, M.D., Circleville, was presented with a plaque in honor of his 25 years of service to the Pickaway County Board of Health. Dr. Moore, who has been in private practice in Circleville since 1952, was appointed health commissioner in 1957.

IAN MURPHY, M.D., Toledo, was elected chief of staff at Riverside Hospital. Also elected were **JOSES YUAN, M.D.**, vice chief of staff; **LUIS GERSTENMAIER, M.D.**, secretary; and **E. C. ABRAMSON, M.D.**, treasurer.

Elected officers of the medical staff of Geauga Community Hospital were: **SIMON OHANESSIAN, M.D.**, chief of staff; **ARTURO**

DIMACULANGAN, M.D., vice chief of staff; and **PATRAWADEE DUANGJAK, M.D.**, secretary-treasurer.

BARRY L. PAXTON, M.D., Urbana, was elected president of the medical staff of Mercy Memorial Hospital. Dr. Paxton is in the practice of internal medicine. Also elected were **THEODORE E. RICHARDS, M.D.**, vice-president, and **JAMES B. HALL, M.D.**, secretary.

DONALD R. SCHERMER, M.D., Cleveland, was appointed chief of the division of dermatology at the Mt. Sinai Medical Center. Dr. Schermer is an attending dermatologist at Mt. Sinai and an assistant clinical professor of dermatology at Case Western Reserve University School of Medicine.

GEORGE N. SPEARS, M.D., Portsmouth, was promoted to medical director at Goodyear Atomic Corporation. Dr. Spears joined Goodyear in 1979 as a staff physician.

ALLEN STRAUS, M.D., Cincinnati, was appointed medical consultant to the Chemical Dependency Treatment Program at Emerson A. North Hospital. Dr. Straus is an executive board member of the Cincinnati Council on Alcoholism and acting medical consultant for the Comprehensive Center for Alcoholic Treatment.

W. HUNTER VAUGHAN, M.D., Steubenville radiologist, was elected chief of staff of St. John Medical Center, and **NICK TEREZIS, M.D.**, was elected chief of staff-elect.

ROBERT WALLACE, M.D., Westlake, was elected president of Lakewood Hospital's medical staff. Dr. Wallace is an anesthesiologist.

GEORGE FRANKLIN WHITE, M.D., Portsmouth, was appointed by Governor James Rhodes as a member

of the board of trustees of Shawnee State Community College. Dr. White is chief of staff-elect at Scioto Memorial Hospital and a member of the board of trustees.

RICHARD R. WILLIS, M.D., Hamilton, was elected to the Fort Hamilton-Hughes Hospital board of trustees. Dr. Willis is an internist and former chief of the hospital's medical staff.

THOMAS WILLIAMS, M.D., Toledo, was elected vice chief of staff, and **W. PATRICK MOONEY, M.D.**, was elected secretary-treasurer of the medical staff of Parkview Hospital.

JAMES V. ZELCH, M.D., Solon, was named director of the new Division of Medical Imaging and Radiological Sciences at Hillcrest Hospital. Dr. Zelch has been a member of the hospital's radiology staff for five years and has had several articles published in professional journals.

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NEWS

a compilation of the latest developments, reports and products of interest to physicians.

edited by
Gina DiBlasio Cummins

Single-dose cystitis cure now available

For many years, treatment for cystitis has usually involved taking prescribed drugs for seven to ten days to kill the bacteria that cause the disease.

This conventional therapy increasingly may be replaced, however, by treatment with single doses of drugs containing sulfisoxazole alone or a combination of trimethoprim and sulfamethoxazole.

In a recent issue of the *Journal of the American Medical Association (JAMA)*, researchers from the University of Manitoba, Canada, report that the overall rate of cure in women with urinary tract infection confined to the bladder and treated with various-sized single doses of medication was 95 percent.

However, an accompanying *JAMA* editorial by Steven A. Lerner, M.D., and Thomas Fekete, M.D., of the University of Chicago School of Medicine, states: "There is no question that single-dose therapy for lower urinary tract infection can be safe and effective." But, they add, "some unanswered questions remain." They suggest that future studies should involve larger numbers of patients and should also include pregnant women.

Questions & Answers About the OSMA GROUP PROFESSIONAL LIABILITY PLAN

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NOTICE

At a public hearing held by the Ohio Department of Insurance on May 18, 1982, concerning group policies for professional liability insurance, representatives of the Ohio State Medical Association (OSMA) testified in favor. Representatives of the Medical Protective Insurance Company, the Ohio Hospital

Association and the Independent Insurance Agents Association of Ohio testified in opposition. The Department hearing officer stated that the record would be kept open for additional comments for another three weeks. Please consult the Ohio State Medical Journal and the OSMAgram for future developments.

OSMA GROUP PROFESSIONAL LIABILITY PLAN

What is the OSMA Group Liability Plan?

First announced at the 1982 OSMA Annual Meeting, the OSMA Group Professional Liability Plan is a unique concept in providing this vital insurance coverage for physicians.

Under this concept, the underwriter of the Plan, Physicians Insurance Company of Ohio, issues a master policy to the policyholder, the Ohio State Medical Association.

Individual coverage is then provided to members of the OSMA who participate in the Plan through a Certificate of Insurance issued from the OSMA's master policy.

Insurance protection for Certificate Holders is *exactly* the same as the protection previously provided by PICO through individual policies. There is absolutely no change in the claims services or other services provided by PICO through the company's current individual policies. Coverage is issued after review of individual applications. The traditional risk classifications previously utilized by PICO remain in effect.

The Group Plan is simply a more efficient and effective method of providing medical professional liability insurance and offers certain distinct advantages to participants. Those advantages, lower premiums and

profit-sharing, are explained in more detail below.

What coverage is offered under the OSMA Group Plan?

Occurrence primary medical professional liability insurance limits available are \$100,000/\$300,000 and \$200,000/\$600,000. Excess coverage will continue to be written directly by PICO, and will be offered through the PICO independent agency network. Excess coverage of \$1 million will be available over *all* primary coverage provided through the Group Plan, and higher limits of up to \$6 million will be provided subject to PICO underwriting approval.

What about rates under the new Plan?

The premiums for all risk classifications under the OSMA Plan are 20% less than the previous PICO premium schedule. The lower rates are made possible because of the operating costs of a group plan.

When does the OSMA Plan take effect?

The effective date of the Plan is July 1, 1982.

If I am a current PICO policyholder, how is my coverage affected?

(continued on page 428)

- Approval of the first effective drug for genital herpes, a sexually transmitted disease that afflicts from 15 to 20 million people in the United States, was announced today by the Food and Drug Administration.

Zovirax brand acyclovir, a breakthrough antiviral drug discovered and developed by Burroughs Wellcome Company, is approved for use against initial infections of herpes genitalis (herpes simplex virus), a venereal disease that causes painful, recurring genital sores.

The new drug will also be used to manage localized herpes simplex infections for both genital and labial herpes (cold sores), in patients whose natural defenses are impaired and unable to control the spread of the infection.

Zovirax will be sold as an ointment and will be available on prescription.

- The Ohio State University Comprehensive Cancer Center has received a \$340,000 National Cancer Institute grant for the clinical study of newly developed anticancer agents, announced Dr. Henry G. Cramblett, vice president of Health Sciences at Ohio State.

"The importance of this grant is that it guarantees us direct access to most new anticancer drugs," said Dr. James A. Neidhart, deputy director of Ohio State's Comprehensive Cancer Center and principal investigator in the study.

The clinical evaluation of these medications is part of the "whole spectrum of research on cancer drugs at Ohio State," he added. "It's just one component of the program in new drug development."

Dr. David Yohn, director of Ohio State's Comprehensive Cancer Center, said he was especially pleased with the selection of the Center for this three-year award, as it was one of only 10 awards made nationally by the National Cancer Institute.

"Mayfield spring clip" inventor

Frank H. Mayfield, M.D. receives top international neurosurgical honors



Frank H. Mayfield, M.D.

Two international neurosurgical societies have accorded high honors to Frank H. Mayfield, M.D., founder of the Mayfield Neurological Institute in Cincinnati.

The World Federation of Neurosurgical Societies has bestowed its highest honor on Dr. Mayfield, naming him one of 15 Honorary Presidents to serve through the Eighth International Congress in 1985. He is appointed for his "internationally recognized and highly esteemed contributions to neurosurgery."

In addition, Dr. Mayfield has been invited to membership in Xeiron, an international organization of neurosurgeons formed four years ago to recognize original scientific contributions to the neurosciences. Dr. Mayfield was chosen for his "very significant pioneering work with the Mayfield spring clips."

Developed by Dr. Mayfield with the assistance of engineer, George Kees, Jr., the spring clip and forceps known as the "Mayfield clip," revolutionized

intracranial surgery. Created in 1952, and in use since 1958, the clip permits the temporary or permanent closure of aneurysms.

A graduate of the Medical College of Virginia, Dr. Mayfield is presently the Director of the Department of Neurosurgery at Christ Hospital, Cincinnati, and continues in private practice with the Mayfield Neurological Institute.

He holds an Honorary Doctor of Science degree from the University of Cincinnati, is a recipient of the Harvey Cushing Medal from the American Association of Neurosurgeons, and has been recognized with Distinguished Service Awards from the American Board of Neurosurgery (1969), the American Medical Association (1980), and the Society of Neurosurgeons (1981).

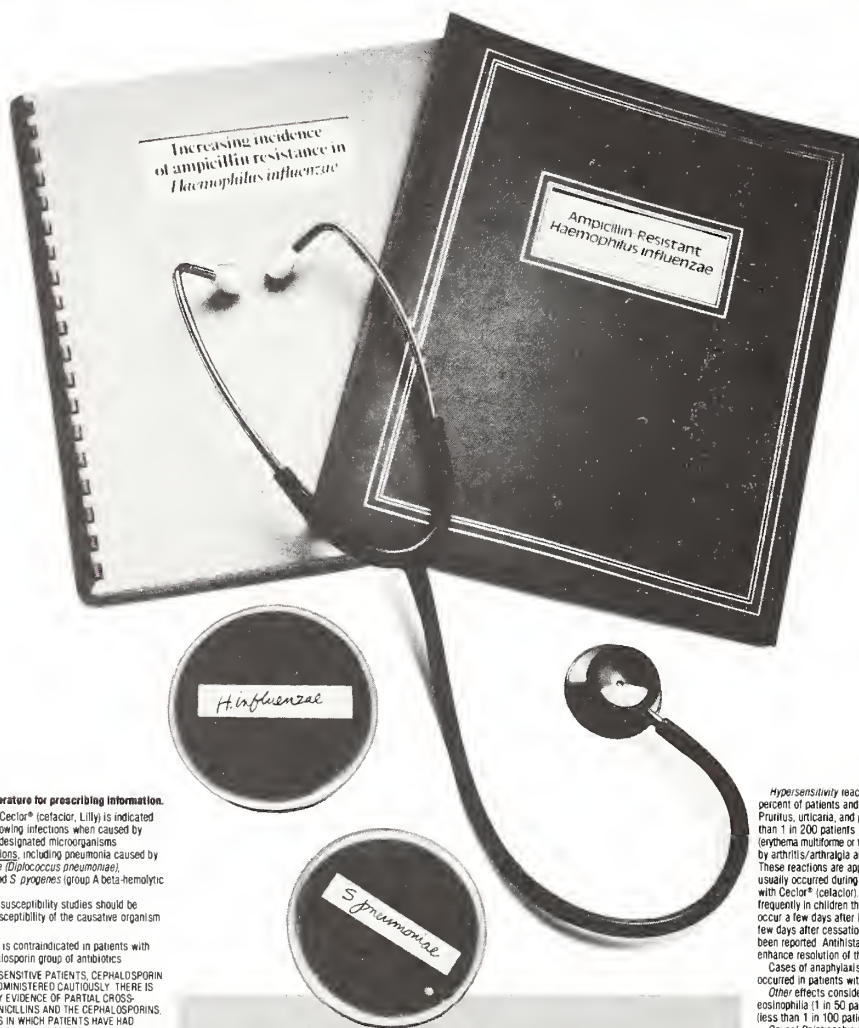
A former president of the Academy of Medicine of Cincinnati, Dr. Mayfield was named a "Great Living Cincinnati" by the Cincinnati Chamber of Commerce in 1980.

Meetings

28th Meeting of the Flying Physicians Association; July 18-23; Pheasant Run, St. Charles, Illinois. This year's theme will be "Continuing Medical Education for the Physician Pilot." For further information, contact: Albert Carriere, Inc., Tangley Oaks, Lake Bluff, Illinois 60044.

Educational Diagnosis and Evaluation in Health Program and Medical Care; July 19-23; Baltimore, Maryland. For further information, contact: Carlita M. Kearney, Office of Continuing Education, 720 Rutland Ave., Rm. 19, Turner Building, Baltimore, Maryland 202 21205.

An added complication... in the treatment of bacterial bronchitis*



Brief Summary

Consult the package literature for prescribing information.

Indications and Usage: Cefaclor (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections: including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefaclor.

Contraindications: Cefaclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES. Antibiotics, including Cefaclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when anti-globulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefaclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefaclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no teratogenic or antenatal effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in fetuses given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below. **Gastrointestinal symptoms** occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Cefaclor.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefaclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefaclor.⁷

Cefaclor®

cefaclor

Pulvules®, 250 and 500 mg

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthritis and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefaclor® (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain: Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic: Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic: Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal: Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

(1002818)

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefaclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

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8. Principles and Practice of Infectious Diseases edited by G.L. Mandell, R.G. Douglas, Jr. and J.E. Bennett, p. 487. New York: John Wiley & Sons, 1979.



Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285. Eli Lilly Industries, Inc., Carolina, Puerto Rico 00630.

200066

Planning in Advance

By Neal L. McCue

Because you are concerned with patient care, and not paper shuffling... because your patients want as little complication as possible paying bills, OMIM has devised a new service to accommodate you both. All it took was a little Advanced Planning.

As a physician, you are most concerned with offering your patients the best possible medical care — but there is another side of your practice: You are sometimes a bill collector, a paper shuffler, an administrator.

By the same token, your patients come to you for your professional advice and your recommended treatment, but they, too, want as little complication as possible when it comes to paying bills and completing insurance forms.

Ohio Medical Indemnity Mutual Corporation, the Blue Shield Plan located in Worthington, shares both concerns. With both you and your patients in mind, OMIM is introducing ADVANCE Plan. Through ADVANCE Plan, physicians and other health care providers agree to accept OMIM's reimbursement as payment in full for services covered at the 100 percent UCR level. Cooperating ADVANCE Plan providers may balance bill their patients for those Basic services that are covered at less than the 100

percent level, up to the UCR amount, and for services not covered by the subscriber's Basic contract, deductibles and copayment amounts. Highlighting the benefits for providers electing to join the ADVANCE Plan is prompt, direct payment from Blue Shield. This payment is automatic, every time, on a fair and equitable basis.

Programs similar to ADVANCE Plan have been sponsored by Blue Shield Plans throughout the country for many years. Actually, about four of five United States practicing physicians participate in such programs. Although these programs have been common in other states, OMIM has made every effort during the past year to develop a program designed uniquely for Ohio.

There are two primary reasons OMIM is initiating an agreement program at this time: the need for market differentiation in order to be more competitive, and the need to more accurately predict future health care costs.

A COMPETITIVE MARKET

Competition for health insurance business has become increasingly intense. With ADVANCE Plan, OMIM will be able to offer potential and existing accounts a means to increase subscriber satisfaction that no other insurance carrier operating in Ohio can provide. By eliminating the need for subscriber involvement in the reimbursement process, the subscriber has a greater sense of predictability regarding health care payments and will be more satisfied with the insurance program. A satisfied subscriber will be more likely to appreciate the employer who provides such insurance.

INCREASING PREDICTABILITY

Purchasers of health insurance will be better able to predict their costs after ADVANCE Plan is in place in Ohio. There is also a potential for reduced subscriber use of OMIM's customer service function, resulting in

lower administrative expenses. Better forecasting of benefit costs and reduced administrative costs will help make OMIM more competitive in terms of premium/benefit performance.

Cost effectiveness and predictability should not be confused with cost containment. Blue Shield will not place arbitrary and unrealistic "caps" on fee increases. The intent is to keep physicians' reimbursement increases in line with economic realities.

ADVANCE PLAN IN REVIEW

All Ohio physicians soon will be receiving the details of OMIM's ADVANCE Plan. Using both direct mail and personal visits, OMIM staff will be explaining the program and encouraging physicians to become involved. The following elements are key to OMIM's ADVANCE Plan:

- ADVANCE Plan physicians agree to accept Blue Shield's reimbursement as payment in full for Basic contract services covered at the 100 percent UCR level. The UCR reimbursement is the crux of ADVANCE Plan. By far, most OMIM subscribers are covered by contracts that reimburse providers on a Usual, Customary and Reasonable basis. The physician's usual fee and the customary fee are normally considered in determining payment, unless there are extenuating circumstances.

- Although ADVANCE Plan physicians agree to accept the UCR reimbursement as full payment, they may still decide when to adjust their own fee schedules. OMIM is taking systematic steps to assure that UCR reimbursements remain fair and equitable; Usual and Customary records will be updated once each year. ADVANCE Plan physicians will automatically receive direct payment from OMIM. Under the current system, the patient has the option to request that OMIM reimburse the physician directly. Under ADVANCE Plan, however, physicians will be assured quick, sure reimbursement on all Basic contract services. This automatic, direct payment is an exclusive feature only for physicians cooperating in ADVANCE Plan. Non-ADVANCE Plan providers will receive

their reimbursement only by collecting from their patients.

- ADVANCE Plan physicians will receive weekly batched checks, a change designed to improve cash flow in medical offices. Physicians will know when to expect payment; check handling will be minimized; and the business side of practice will run more smoothly.

Blue Shield believes the program is good business theory put into practice

- There is an option of electronic funds transfer which will allow those ADVANCE Plan physicians selecting this feature to have reimbursement checks deposited directly into their bank accounts. This transaction will be handled automatically, and the physician will receive a detailed record of the transfer. This feature further enhances cash flow and eliminates the chances of lost or stolen checks.

- ADVANCE Plan physicians have another option of adding an automated paperless claims data entry

system in their offices. Known statewide as the Ohio Provider Entry Network (OPEN), the system gives offices a direct data link to OMIM for instant claims filing. Cooperating ADVANCE Plan providers may use OPEN's terminal entry system at a significant discount.

- A new toll-free telephone service is in place at Blue Shield, with a staff specially trained to answer only questions from physicians or other providers about ADVANCE Plan procedures or claims.

- A new Explanation of Benefits form for the subscriber will improve understanding of what OMIM's benefit payment represents, what is not covered and what balance is due (if any) on each processed claim. This will enhance collection of legitimate balances. Similar information will be included on the detailed benefit check voucher accompanying OMIM's payments to you.

Blue Shield believes the program is good business theory put into practice. Especially considering economic uneasiness and the pressures of holding down costs, ADVANCE Plan has many benefits for everyone included in the health insurance sphere.

Neal L. McCue is Vice President of Health Affairs, Ohio Medical Indemnity Mutual Corporation.



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DESCRIPTION: Each gram contains: Aerosporin® (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs, in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. *Prophylactically*, the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neo-

mycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching, it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. P.M.L.



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local and state auxiliary societies was from the sale of coloring books using health-related cartoons and advice developed by many of the local auxiliaries. To date, over 7,000 books have been sold.

Many, but not all, of the counties have active auxiliaries and participate in local political campaigns, health issues and public service projects, eg, school hearing and vision screening, health fairs, etc.

There has been a strengthening of the Medical Association and Auxiliary ties over the years. Regular reports to the House of Delegates by the Auxiliary president have kept us abreast of their many activities and

medical resource program (similar to our OSMA key man) has helped legislators understand the complexities of health-related legislation. This

The Auxiliary initiated a "Day at the Legislature" in 1973 . . . designed to promote better relations with Ohio Legislators on a one-to-one basis.

Auxiliary members assemble in the House of Representatives at last year's "Day at the Legislature."





The Auxiliary is presided this year by Mrs. Rose Vesper.

now the president has been invited to all our Council meetings to help foster closer cooperation between our organizations. The Council is able to know what projects are under way by the Auxiliary, and the Auxiliary President may make suggestions and recommendations concerning our goals and projects. This communication flow permits greater efficiency and effectiveness in a time of a rapidly changing health care environment.

The recent large increase in OSMA membership to 16,000 has not been matched by the Auxiliary. Over 4,300 spouses belong to OSMA but recent constitutional changes will permit resident and student spouses to join. A major negative factor on membership seems to be the perception by some physicians that the Auxiliary is a card/luncheon club of little consequence and not worth the expenditure of \$11.00 for AMA, \$18.00 for state and an average of \$10.00 for county dues. When you consider the

activities and contributions of this energetic, dedicated and gifted group of individuals, the achievements/dues dollar ratio is truly remarkable.

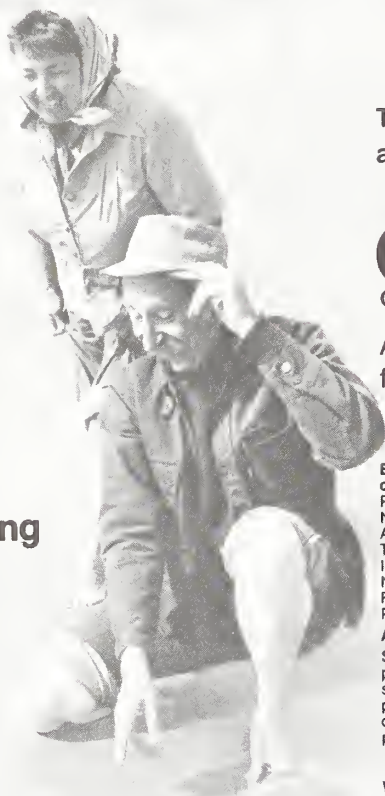
My years as chairman of the OSMA/Auxiliary Liaison Committee have made me a firm believer (not that I was not before) in the Auxiliary's

There has been a strengthening of the Medical Association and the Auxiliary.

functions and I urge all of my fellow OSMA members to support the Auxiliary and its members and ask your spouse to join if he/she is not now a member. It will be a truly gratifying experience for both of you and the people we all care most about, our patients, will be the ultimate winners.

S. Baird Pfahl, Jr., M.D. is President-Elect of the OSMA.

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**A gentle cerebral stimulant and vasodilator
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Riboflavin	2 mg.
Pyridoxine HCL	3 mg.

AVAILABLE: Bottles 100, 500, 1000

SIDE EFFECTS: Most persons experience a flushing and tingling sensation after taking a higher potency nicotinic acid. As a secondary reaction some will complain of nausea, sweating and ab-

dominal cramps. The reaction is usually transient.

INDICATIONS: As a cerebral stimulant and vasodilator.

RECOMMENDED GERIATRIC DOSAGE: One capsule three times daily adjusted to the individual patient.

WARNING: Overdosage may cause muscle tremor and convulsions.

CONTRAINDICATIONS: Epilepsy or low convulsive threshold.

CAUTION: Federal law prohibits dispensing without prescription. Keep out of reach of children.

Write for literature and samples

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Medical Malpractice

An Ohio Survey

By Sidney F. Miller, M.D.

A medical malpractice survey was sent to the members of the Ohio Chapter of the American College of Surgeons in January of 1981. Previous surveys of the Chapter had been carried out in 1969 and 1974. This article contains a summary of the findings of that survey. Specific conclusions of the survey include: (1) most respondents felt the malpractice problem continued to exist in the State of Ohio, however, apparently premiums have stabilized; (2) the percentage of responders indicating that

they had been sued was significantly higher than in either of the two previous surveys; (3) members of the Chapter again indicated their willingness to meet with insurance companies and Bar Associations to try to improve the malpractice problem, however, they indicated that little activity in medical arbitration was being undertaken in the State of Ohio; and (4) again the survey indicated a significant portion of suits were settled out of court, almost always at the insurance company's direction.

In January of 1981, a medical malpractice questionnaire was sent out to the 2,005 members of the Ohio Chapter of the American College of Surgeons. Eight hundred and seven questionnaires were returned to the project chairman. This study was undertaken to evaluate the current malpractice problem in the State of Ohio as perceived by members of the Ohio Chapter. Additional data were obtained from Dr. Franklin Shively, Jr., who performed two previous malpractice surveys for the Ohio Chapter in 1969 and 1974.

This report summarizes the results of the current survey, and additionally draws comparisons and contrasts between the current survey and the previous surveys. Chi-squared analysis

of differences encountered between the various surveys was undertaken where appropriate. Significant differences are noted with appropriate p-values. Other comparisons, not so noted, did not show any statistical difference when chi-squared analysis was performed.

Over half of the responders indicated they felt there was a medical malpractice problem in Ohio.

1981 Survey

The 1981 survey consisted of 31 questions designed to assess the age

and type of practice of the individual responders as well as their malpractice experience and attitudes related to the malpractice situation in Ohio. 41.8% of the responders indicated that their specialty was general surgery. The mean age of the responders was 51 years. The range was from 31 to 79 years of age. 48% were in solo practice and 21% were in partnerships. 21% were in group practice and 4.8% were hospital based.

Malpractice Experience

52.9% of the responders indicated they felt there was a medical malpractice problem in the State of Ohio. 94.5% carried malpractice insurance. 17.8% said that their

(continued on page 401)

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The combination of propranolol HCl, the world's most trusted beta blocker, and hydrochlorothiazide, the standard among diuretics, enables *INDERIDE* to exert an additive antihypertensive effect.^{1,2} In fact, a propranolol/hydrochlorothiazide regimen maintained blood pressure below 90 mm Hg in 81.8% to 86.4% of patients followed for 6 to 18 months of therapy.¹

Low thiazide dosage means reduced risk of hypokalemia.

When thiazides are prescribed in doses greater than 50 mg/day, the potential for hypokalemia increases substantially. What's more, the greater the fall in serum K⁺, the greater the risk of hypokalemia-induced PVCs.^{3,4}

With *INDERIDE*, the additive hypotensive effect of propranolol HCl allows the effective dose of hydrochlorothiazide to be kept low (25 mg b.i.d.). And by lowering the daily dose of diuretic, *INDERIDE* also lowers the potential for diuretic-induced side effects. Potassium problems are less likely to occur—yet blood pressure can be controlled consistently.



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Each tablet contains *INDERAL*[®] (propranolol HCl) 40 mg or 80 mg, and hydrochlorothiazide 25 mg | **B.I.D. 40/25
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When you know you need more than a thiazide.

Please see Brief Summary of Prescribing Information on following page.

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(INDERAL®)
and hydrochlorothiazide

No. 474—Each IINDERIDE®-40/25 tablet contains Propranolol hydrochloride (INDERAL®)	40 mg
Hydrochlorothiazide	25 mg
No. 476—Each IINDERIDE®-80/25 tablet contains Propranolol hydrochloride (INDERAL®)	80 mg
Hydrochlorothiazide	25 mg

WARNING: This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

DESCRIPTION: IINDERIDE combines two antihypertensive agents, IINDERAL (propranolol hydrochloride), a beta-adrenergic blocking agent, and hydrochlorothiazide, a thiazide diuretic-antihypertensive.

INDICATION: IINDERIDE is indicated in the management of hypertension. (See boxed warning.)

CONTRAINDICATIONS: **Propranolol hydrochloride (INDERAL®):** Propranolol hydrochloride is contraindicated in 1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS: **Propranolol hydrochloride (INDERAL®):** **CARDIAC FAILURE:** Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) If cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn, b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA: Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

USE IN PREGNANCY: **Propranolol hydrochloride (INDERAL®):** The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

Hydrochlorothiazide: Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers: Thiazides appear in breast milk. If the use of the drug is deemed essential, the patient should stop nursing.

PRECAUTIONS: **Propranolol hydrochloride (INDERAL®):** Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncope attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause are: dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements such as foods with a high potassium content.

Any chloride deficit is generally mild, and usually does not require specific treatment except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

ADVERSE REACTIONS: **Propranolol hydrochloride (INDERAL®):** Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Miscellaneous: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

Hydrochlorothiazide: **Gastrointestinal:** anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

Central Nervous System: dizziness, vertigo, paresthesias, headache, xanthopsia.

Hematologic: leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular: orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: purpura, photosensitivity, rash, urticaria, necrotizing angitis (vasculitis, cutaneous vasculitis), fever, respiratory distress including pneumonitis, anaphylactic reactions.

Other: hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

DOSEAGE AND ADMINISTRATION: The dosage must be determined by individual titration (see boxed warning).

Hydrochlorothiazide is usually given at a dose of 50 to 100 mg per day. The initial dose of propranolol is 40 mg twice daily and it may be increased gradually until optimum blood pressure control is achieved. The usual effective dose is 160 to 480 mg per day.

One to two IINDERIDE tablets twice daily can be used to administer up to 320 mg of propranolol and 100 mg of hydrochlorothiazide. For doses of propranolol greater than 320 mg, the combination products are not appropriate because their use would lead to an excessive dose of the thiazide component.

When necessary, another antihypertensive agent may be added gradually beginning with 50 percent of the usual recommended starting dose to avoid an excessive fall in blood pressure.

OVERDOSAGE OR EXAGGERATED RESPONSE: The propranolol hydrochloride (INDERAL®) component may cause bradycardia, cardiac failure, hypotension, or bronchospasm.

The hydrochlorothiazide component can be expected to cause diuresis. Lethargy of varying degree may appear and may progress to coma within a few hours, with minimal depression of respiration and cardiovascular function, and in the absence of significant serum electrolyte changes or dehydration. The mechanism of central nervous system depression with thiazide overdosage is unknown. Gastrointestinal irritation and hypermotility can occur; temporary elevation of BUN has been reported, and serum electrolyte changes could occur, especially in patients with impairment of renal function.

TREATMENT: The following measures should be employed. **GENERAL:** If ingestion is, or may have been, recent, evacuate gastric contents taking care to prevent pulmonary aspiration. **BRADYCARDIA:** Administer atropine (0.25 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously. **CARDIAC FAILURE:** Digitalization and diuretics. **HYPOTENSION:** Vasopressors, e.g., levaterenol or epinephrine. **BRONCHOSPASM:** Administer isoproterenol and aminophylline. **STUPOR OR COMA:** Administer supportive therapy as clinically warranted. **GASTROINTESTINAL EFFECTS:** Though usually of short duration, these may require symptomatic treatment. **ABNORMALITIES IN BUN AND/OR SERUM ELECTROLYTES:** Monitor serum electrolyte levels and renal function; institute supportive measures as required individually to maintain hydration, electrolyte balance, respiration, and cardiovascular-renal function.

HOW SUPPLIED: No. 474—Each IINDERIDE®-40/25 tablet contains 40 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 476—Each IINDERIDE®-80/25 tablet contains 80 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100.

References: 1. Veterans Administration Cooperative Study Group on Antihypertensive Agents. JAMA 237:2303 (May 23) 1977. 2. Bravo, E.L., Tarazi, R.C., and Dustan, H.P. N Engl J Med 292:66 (Jan 9) 1975. 3. Hollifield, J.W., and Slaton, P.E. Acta Med Scand. [Suppl] 1647:67, 1981. 4. Holland, O.B., Nixon, J.V., and Kuhnert, L. Am J Med 70:762 (Apr) 1981.

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Medical Malpractice: An Ohio Survey

Malpractice Attitudes

A number of questions about attitudes regarding the malpractice problem were included in the questionnaire. 63% of the responders felt that insurance companies were too ready to settle suits irrespective of the validity of the suit. 80.2% felt that efforts should be made to jointly

63% of the responders felt that insurance companies were too ready to settle suits . . . regardless of their validity.

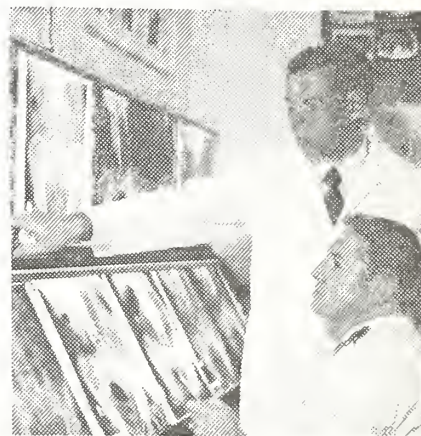
consider liability problems with local and national Bar Associations and insurance companies. 80.7% felt that mandatory presentation of malpractice claims to a medicolegal investigating committee should be undertaken. 86.4% felt that plaintiff bonds should be mandatory to pay court costs for

unsuccessful suits. 81.4% of the responders felt that the continuancy fee and the use of res ipsa loquitur should be banned from malpractice cases. 90.3% of the responders felt that the questions of statutes of limitation should be invoked prior to the trial of negligence suits. 85% of the responders favored some type of arbitration but less than half (48.4%) indicated that there was an active medical malpractice arbitration program in their area. 53.2% of the responders felt that predefined compensation for medical malpractice similar to Workmen's Compensation would be beneficial and 59.2% felt that some type of "no fault" insurance similar to flight travel insurance was indicated. Only 45.5% of the responders indicated their hospital had a risk management program.

Finally, second opinion programs were addressed in this year's survey. Second opinion programs are being touted as the final answer to the medical malpractice problem. Only 8.9% of the responders indicated they felt that these second opinion programs for elective surgery would have a significant effect in reducing malpractice claims. Additionally, 44.1%

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of the responders indicated that they did not participate in second opinion programs. Suggestions also have been made that an active hospital risk management program would be the final solution to the malpractice problem. When queried about risk management programs, only 45.9% of the responders indicated that there was such a program in their institution.

Comparison With Previous Surveys

Although the 1981 survey was not identical to past surveys, a large part of it was designed to duplicate answers to questions obtained in the 1969 and 1974 surveys. Differences were appreciated over the years in both the nature of the responders, indicating possible changes in the nature of the Chapter itself, as well as differences in both attitudes and the malpractice problem.

In 1969, 52.4% of the responders indicated they were general surgeons. This year, only 41.8% were general surgeons which was a figure fairly similar to the 1974 figure (44.3%). The difference between the 1969 figures and those for 1974 and 1981 were significantly different ($p < .01$). OB-GYN compromised 10.2% of the responders in 1969, 10.8% of the responders in 1974, but only 7.3% of the responders in 1981. There were twice as many surgeons in 1981, indicating a

subspecialty of vascular surgery as in 1974 (1.3% to 3.6%). There was also an increase in the percentage of urologists from 5.6% in 1969 and 5.2% in 1974 to 6.9% in 1981. The percentage of otolaryngologists increased from 4.2% in 1969 to 5.9% in 1981, while the percentage of plastic surgeons almost doubled from 2.9% to 4.5% in the past 12 years (see Table).

One of the most marked shifts appreciated was the change in age

There is less heard about malpractice today, but a higher percentage of the responders indicated that they had been sued.

distribution of the responders. In 1969 only 1.8% of the responders were in their 30s, while this year 16.2% were in this age group. In 1969, 33.4% of the responders were less than 50 years of age, while this year almost half (48.2%) were under 50 years of age (difference significant $p < .001$).

It is interesting to note that there is less heard about the malpractice

problem today, but a higher percentage of the responders indicated that they had been sued than in any of the previous surveys. In 1969, only 31.6% of the responders indicated that they had been sued in the previous five years. In 1974, 34.3% had been sued while this year 52.8% indicated that they had been sued in the previous five years (differences significance $p < .001$). As in previous years, only about a quarter of the suits actually go to court. (In 1969 - 21.2%, 1974 - 26.5%, 1981 - 23%.) Out-of-court settlements were affected by the insurance company in an alarmingly stable percentage over the past 12 years (1969 - 72.7%, 1974 - 70.4%, 1981 - 71.8%).

As in the 1969 survey, 63% of the responders indicated that the insurance companies were too ready to settle claims that were not warranted. 80.2% of the responders again felt that meetings with Bar Associations and insurance companies would be beneficial but this percentage is significantly lower than that of the 1969 study ($p < .01$). Again, the members of the Chapter felt quite strongly that a plaintiff's bond for court costs of unwarranted suits was indicated (1969 - 87%, 1981 - 86.4%). In 1969 only 5.2% of the responders indicated that they had difficulty obtaining malpractice insurance, compared to 8.1% in 1981.

Ohio Malpractice Survey

	1969	1974	1981
General Surgery	52.4	44.3	41.8*
General and Vascular	—	1.3	3.6
Urology	5.6	5.2	6.9
Colon and Rectal	1.9	1.8	1.3
Cardiovascular	4.6	1.5	5.5
ENT	4.2	3.0	5.9
Eye	3.2	5.2	5.3
OB-GYN	10.2	10.8	7.3
Plastic	2.9	5.0	4.5
Orthopedic	10.5	10.2	9.0
Neurological	4.0	6.0	5.3
Pediatric	.8	—	1.6
Miscellaneous	—	4.8	1.4

Specialty (percentage)

*Difference Statistically Significant ($p < .01$)

Medical Malpractice. An Ohio Survey.

Discussion

The percentage of responders indicating their specialties as general surgery was relatively stable from the 1974 survey, however there was a marked decline in the percentage of general surgeons since 1969 when over half indicated that their specialty was general surgery. There is a significant change in the age composition of the responders in this year's survey compared to previous surveys with almost half (48.2%) of this year's responders being less than 50 years of age. Whether this represents a true change in the age composition of the Chapter, fewer surgeons over 50 years remaining in practice, or fewer responses by the older members of the Chapter, cannot be determined.

Although there has been a problem in the past with escalating premiums, it would appear from this year's survey that there has been some stabilization in the premiums. In both 1969 and 1974, a high percentage of

the responders indicated that there had been a greater than 100% increase in their premiums. In this year's survey, only about a quarter of the responders indicated that they have experienced this type of increase. A majority of the responders indicated that their annual premium was less than \$10,000 per year (72.8%) while only 1.3% of the responders indicated that their annual premium was greater than \$25,000 per year. (On the day this data was presented to the Ohio Chapter of the American College of Surgeons, the Physicians Insurance Company of Ohio announced a 25% premium increase.)

Although there is less publicity about the malpractice problems in the State of Ohio today than in the past, a significantly higher percentage of responders indicated that they had been sued in the previous five years than in either of the previous surveys. In 1969, 31.6% of the responders indicated that they had been sued while in 1974, 34.3% had been sued.

This year, 52.8% had been sued. This increase was statistically significant.

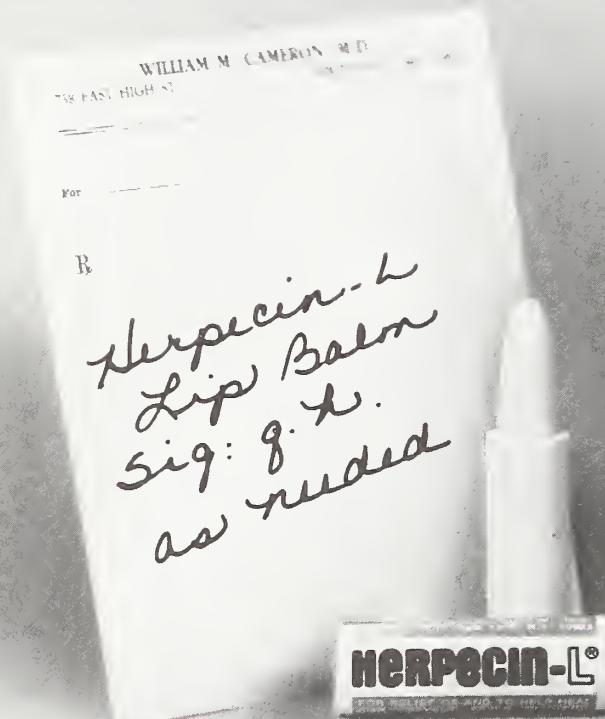
Again, it is quite apparent that very few suits go to court and that insurance companies appear too ready to settle out of court. In 1969, only 21% of the suits went to court; in 1974, 26% went to court; and 1981, 23% went to court. In 1969, 72% of the cases were settled out of court; 1974, 70% were settled out of court and again in 1981, 72.8% were settled out of court. In both the 1969 and 1980 survey, almost two thirds of the members of the Chapter felt that insurance companies and lawyers were too ready to settle suits out of court regardless of the validity of the suit.

Summary

The following summary points are suggested by the 1981 survey and comparisons with the previous surveys:

1. The percentage of responders indicating that their specialty was general surgery is essentially

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Medical Malpractice. An Ohio Survey.

unchanged since 1974, however, there has been a significant change since 1969. The age of the responders is significantly lower than in the previous surveys with almost half of the responders now being under 50 years of age.

2. Half the responders felt that there continued to be a medical malpractice problem and the overwhelming majority carried malpractice insurance. Although there have been problems in the past with escalating premiums, over 70% of the responders indicated that their premiums were less than \$10,000, and a much lower percentage than in previous surveys indicated that there had been significant increases in their premiums. Few had difficulty obtaining malpractice insurance. Two thirds indicated that either old malpractice carriers have reentered their markets or new carriers have become available in the last several years.

3. Although there is less publicity regarding the malpractice problem, a

significantly higher percentage of responders had been sued than in either of the previous surveys. Almost 70% of the responders sued, however, had only been sued once or twice with

Responders feel quite strongly that a plaintiff bond should be posted to pay court costs when suits are denied.

a minority (3.9%) having been sued five or more times. Very few suits go to court and insurance companies appear too ready to settle suits. The majority of suits are settled out of court. These attitudes and findings have been consistent throughout the last 12 years.

4. Members of the Ohio Chapter again indicated their willingness to

meet with insurance companies and Bar Associations to try and improve the malpractice problem. They continue to be willing to submit to local medicolegal investigating committees and feel quite strongly as they did in 1969 that a plaintiff bond should be posted to pay court costs when suits are denied. 90% of the responders felt that the statute of limitations should be allowed to be introduced as evidence in a malpractice suit. 85% of the responders indicated their willingness to participate in some type of arbitration program, however, less than half indicated that there was any type of active malpractice arbitration in their areas. Slightly over half felt that some type of predefined compensation similar to Workmen's Compensation or no-fault insurance was needed and would be helpful.

Sidney F. Miller, M.D. is an OSMA member, and practices surgery in Dayton, Ohio.

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BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

CONTRAINDICATIONS

INDERAL is contraindicated in: 1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE. Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta-blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. INDERAL acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by INDERAL's negative inotropic effect. The effects of INDERAL and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during INDERAL therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, INDERAL therapy should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS DURING ANESTHESIA with agents that require catecholamine release for maintenance of adequate cardiac function, beta blockade will impair the desired inotropic effect. Therefore, INDERAL should be titrated carefully when administered for arrhythmias occurring during anesthesia.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, INDERAL should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since INDERAL is a competitive inhibitor of beta receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA. Because of its beta-adrenergic blocking activity, INDERAL may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY. The safe use of INDERAL in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit.

Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of INDERAL may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash; fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Miscellaneous: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

ORAL

DOSAGE AND ADMINISTRATION

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 40 mg INDERAL twice daily, whether used alone or added to a diuretic. Dosage may be increased gradually until adequate blood pressure is achieved. The usual dosage is 160 to 480 mg per day. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

While twice-daily dosing is effective and can maintain a reduction in blood pressure throughout the day, some patients, especially when lower doses are used, may experience a modest rise in blood pressure toward the end of the 12 hour dosing interval. This can be evaluated by measuring blood pressure near the end of the dosing interval to determine whether satisfactory control is being maintained throughout the day. If control is not adequate, a larger dose, or 3 times daily therapy may achieve better control.

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

INTRAVENOUS

The intravenous administration of INDERAL has not been evaluated adequately in the management of hypertensive emergencies.

OVERDOSAGE OR EXAGGERATED RESPONSE

IN THE EVENT OF OVERDOSAGE OR EXAGGERATED RESPONSE, THE FOLLOWING MEASURES SHOULD BE EMPLOYED:

BRADYCARDIA—ADMINISTER ATROPINE (0.25 to 1.0 mg). IF THERE IS NO RESPONSE TO VAGAL BLOCKADE, ADMINISTER ISOPROTERENOL CAUTIOUSLY.
CARDIAC FAILURE—DIGITALIZATION AND DIURETICS.
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Reference: 1. Freis, E. D. Hypertension (Suppl. II) 3:230 (Nov-Dec) 1981.

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CME

How is it measuring up?

By Ronald J. Markert, Ph.D.
John Barton, Ph.D.
Alvin Rodin, M.D.

Participant learning and change in practice behavior were measured for a large number of continuing medical education programs. For 37 programs, participant learning was measured by means of the pre/post test technique. For 20 programs, change in practice behavior was measured through a three- to six-month follow-up questionnaire.

In the questionnaire participants were asked if the program resulted in changes in

diagnostic methods, treatment regimens, follow-up procedures, or attitudes. Participants were asked to cite at least one specific change in practice behavior resulting from the program. The continuing medical education programs were found to be effective in increasing participant learning, and results suggested that positive change in practice behavior also occurred.

The most important outcomes espoused by sponsors of continuing medical education (CME) programs are learning by participants, positive changes in practice behavior, and related benefit to patients as measured by improved health status. Yet, it has long been recognized that CME programs generally are inadequate in their evaluation efforts with regard to measuring these outcomes. The history of the development of CME reveals that agencies charged with accrediting sponsors have spoken in vague terms on the issue. For example, The Accreditation Council for Continuing Medical Education, in a recent draft of *Essentials for the Accreditation of Sponsors of Continuing Medical Education*, says hesitantly, "The evaluation of learning activities should assess . . . if feasible, the effect of learning . . . on physician behavior." This paper describes the experience of the Group on Continuing Medical Education at the Wright State University School of

Medicine in measuring participant learning and change in practice behavior.

Review of the Literature

Bertram and Brooks-Bertram,¹ in their review of the literature related to CME evaluation, cite 65 articles containing 113 studies. Of the 113 studies, 27 assessed physician knowledge, three assessed manual or

knowledge. The three studies which assessed skill used many different methods: practical test for identifying unknown heart sounds, hospital chart review, participant evaluation of the course, content analysis of answers related to a filmed patient interview, questionnaire on office practice, participant interviews to elicit improvement in practice, and evaluation by clinical chiefs. Among

"The evaluation of learning activities should assess . . . if feasible, the effect of learning on physician behavior."

interpersonal skill, 24 assessed physician behavior and four assessed patient health status. Paper and pencil tests such as multiple choice exams were used in more than half the studies which measured physician

the studies which measured physician behavior, record review (10 studies) and questionnaire/survey (eight studies) were most frequently used. In the four studies which assessed patient health status some form of

chart audit or patient follow-up was used. Following the terminology of Campbell and Stanley,² the authors report that the cited studies used predominantly the less scientific preexperimental evaluation design. Only four studies used the experimental evaluation design (randomization and control group). The authors also point out that most studies were flawed by (a) measurement instruments for which reliability and validity had not been established, (b) failure to use statistical tests of significance or failure to report the specifics when tests were used, and/or (c) inadequate description of population and sample characteristics, sample selection, and response rate.

Lloyd and Abrahamson,³ in their report on the effectiveness of continuing medical education, cite 47 articles which used objective methods of evaluating CME. The authors classified CME program outcomes in terms of physician competence, physician performance, and patient health status. Physician competence typically was measured by multiple choice tests and/or additional questionnaires in the 22 studies reported. Physician performance was assessed by chart audit in most of the 26 studies cited. Patient health status

CME programs at the Chicago Medical School in which pre/post multiple choice exams were used to assess knowledge gain. Apparently no subsequent follow-up attempts or control groups were used.

Stein⁵ reports eight research studies in which a CME program is shown to improve physician performance. The studies are lauded as models for evaluation methodology which measure participant learning, specifically physician performance. Evaluation techniques used in one or more of the eight studies were (a) written examinations to assess knowledge gain, (b) medical care evaluation procedures such as chart audit, (c) follow-up self-report by physicians on changes in performance, (d) referral patterns, (e) attitudinal questionnaires, and (f) audience reaction.

Program Description

Briefly, CME program development at the Wright State University School of Medicine will be described. The identification of need for a CME program may come from a medical audit, literature review, new research findings, perceived needs of practicing physicians, or need identification by medical school faculty. When a

actually exists. After the problem has been defined and validated, the planning committee determines what cognitive, affective, and/or psychomotor behavior changes must take place in the physician in order to reduce or eliminate the problem. These changes are then stated in terms of objectives which can be measured. The objectives for the program are used by the planning committee to determine the content, resources, instructional methods, and evaluation procedures to be used. Next, program presenters are asked to develop educational activities which will accomplish the objectives. Program presenters are also requested to develop test items (multiple choice, true-false, or case problems) which can be used in pre/post tests.

Evaluation Methodology

To measure participant learning for a CME program, pre/post tests are used. The test is administered prior to the beginning of the program to determine the entry level of knowledge. This activity also acts as an advanced organizer for the participant and helps him to identify the key concepts to be covered in the program.⁶ At the end of the program the same test items are administered as a posttest. The difference between pretest and posttest is a measure of gain or loss in knowledge based upon the instructional activities of the program. At the program's conclusion, the participant is given an answer key for grading his pre/post tests to determine what has been learned.

Three to six months after the program, the participant is sent a questionnaire entitled **Impact of Continuing Medical Education Programs on Practice**. With the instrument is sent the agenda and objectives for the program. The participant is asked if he is doing anything differently as a result of the program. If the answer is affirmative, the participant is requested to indicate if the changes are in diagnostic methods, treatment regimens, follow-up procedures, or attitude changes. Finally, the participant is requested to give at least one example of how he has changed his practice behavior

The identification of need for a CME program may come from a medical audit, literature review, new research findings, perceived needs or need identification.

was evaluated in only four studies. Three methods were used: state health department statistics, chart audit, and patient follow-up. Nearly all studies used the pre/post technique (ie, assessment immediately prior to the program and immediately after the program). About one quarter of the studies used a follow-up procedure implemented some time distant from program completion. About one third of the studies used a control group but only four studies used randomly assigned equivalent control groups.

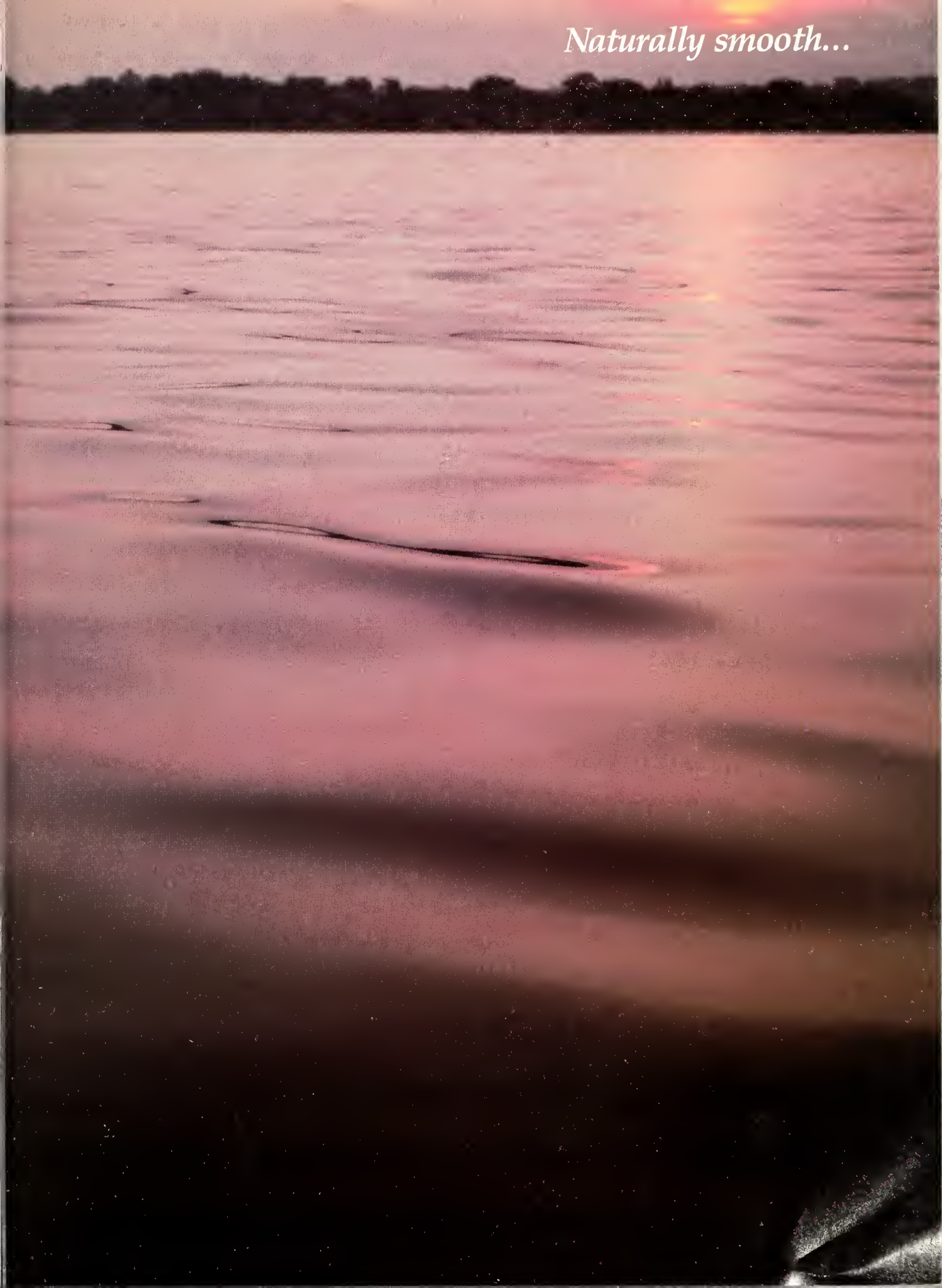
Alberti and Gomilla⁴ describe 11

medical topic area has been determined, a planning committee is created to guide the development of the program. The planning committee consists of (a) practicing physicians representing the medical specialties involved, (b) medical school faculty members from the basic science and clinical areas involved, and (c) staff members from the medical school's Department of Postgraduate Medicine and Continuing Education.

The first task of the planning committee is to define the problem and to validate that the problem

(continued on page 415)

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namely hyponatremia, hypochloremic alkalosis and hypokalemia. These determinations are particularly important when there is excessive vomiting or diarrhea, or when parenteral fluids are administered. Patients treated with diuretics or corticosteroids are susceptible to potassium depletion. Caution should be observed when administering to patients with gout or hyperuricemia or those with severely impaired renal function. Insulin requirements may be affected in diabetics. Hyperglycemia and glycosuria may occur in latent diabetes. Chloride deficit and hypochloremic alkalosis may occur. Orthostatic hypotension may occur. Dilutional hyponatremia may occur. **Adverse Reactions:** Constipation, nausea, vomiting, anorexia, diarrhea, bloating, epigastric distress, intrahepatic cholestatic jaundice, hepatitis, syncope, dizziness, drowsiness, vertigo, headache, orthostatic hypotension, excessive volume depletion, hemoconcentration, venous thrombosis, palpitation, chest pain, leukopenia, urticaria, other skin rashes, dryness of mouth, hypokalemia, hyponatremia, hypochloremia, hypochloremic alkalosis, hyperuricemia, hyperglycemia, glycosuria, raised BUN or creatinine, fatigue, muscle cramps or spasm, weakness, restlessness, chills, and acute gouty attacks. **Usual Initial Once-Daily Dosages:** mild to moderate essential hypertension—2½ to 5 mg; edema of cardiac failure—5 to 10 mg; edema of renal disease—5 to 20 mg. Dosage adjustment is usually necessary during the course of therapy. **How Supplied:** Tablets, 2½, 5 and 10 mg.

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based upon his participation in the program.

Results

Beginning in March 1977, each Wright State University CME program has contained a pre/post test of knowledge. Table 1 reports the group means for pretest and posttest and the mean percent change from pretest to posttest for each CME program.

Using the data reported in Table 1 and establishing 70% as a passing score for group means, the McNemar Test corrected for continuity (ie, small values in some cells) was applied to examine the hypothesis that Wright State University CME programs are effective in increasing knowledge among participants. Table 2 reports the results.

The X^2 value of 11.08 is statistically significant at the .001 level. Thus, it can be concluded that the movement of groups means from below passing to above passing is a real change and not a chance result. More generally, it

The participant is requested to give at least one example of how he has changed his practice behavior, based upon his participation in the program.

can be concluded that Wright State University CME programs are effective in increasing the knowledge of participants.

In addition, beginning in February 1979, participants were asked, three to six months after their participation in a CME program, if their practice behavior had changed. The mean response rate for the 20 programs was 39%. Table 3 reports in percent the change in practice behavior.

The mean percent of physicians indicating that their practice behavior changed was 60.1 while 35.3 reported no change in practice behavior. The relatively low response rate urges caution in the interpretation of these data, and thus no inferential statistical

Table 1

Pretest and Posttest Group Means for 37 Continuing Medical Education Programs

Program	Group Mean Pretest (%)	Group Mean Posttest (%)	Mean % Change
1 Pain I	53	66	+13
2 Infectious Diseases I	44	68	+24
3 Clinical Allergy	38	51	+13
4 Obstetrics/Gynecology I	62	76	+14
5 Hemophilia	53	72	+19
6 Neurology	41	55	+14
7 Genetics	43	48	+ 5
8 Sports Medicine	64	77	+13
9 Pain II	36	48	+12
10 Diabetes	39	62	+23
11 Industrial Disease	57	67	+10
12 Nutrition and Liposurgery	44	61	+17
13 Clinical Pharmacology	60	70	+10
14 Obstetrics/Gynecology II	51	66	+15
15 Aging	57	71	+14
16 Stress Management	52	62	+10
17 Renal Stones	42	59	+17
18 Infectious Diseases II	43	63	+20
19 ENT for the Primary Care Physician	41	59	+18
20 Preventive Sports Medicine	59	76	+17
21 Alcohol Intervention	36	51	+15
22 Pain III	44	61	+17
23 Pediatric Review	51	59	+ 8
24 Gastroenterology Update	48	57	+ 9
25 Comprehensive Health	76	79	+ 3
26 Cancer Surgery	32	49	+17
27 Nonproductive Pregnancy in the First Trimester	60	72	+12
28 Anaerobic Infections	50	74	+24
29 Law and Ethics in Medicine	57	78	+21
30 Modern Concepts of Aerospace Activities	44	58	+14
31 Clinical Oncology for Primary Care Physicians	70	77	+ 7
32 Nutrition	66	77	+11
33 Sports Medicine II	56	73	+17
34 Cancer Pain	52	65	+13
35 Diagnostic and Statistical Manual of Mental Disorders	55	65	+10
36 Geriatric Medicine	63	76	+13
37 Current Approaches to Developmental Problems	63	79	+16
GRAND MEAN	51.4	65.6	14.2



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test was applied. Nevertheless, the results are suggestive of a noteworthy change in practice behavior due to the CME programs of the Wright State University School of Medicine.

Discussion

The continuing medical education programs of the Wright State University School of Medicine have been shown to increase the knowledge of participants and possibly to change practice behavior. The evaluation

patterns, self-reports and observations of practice behavior, patient follow-ups, simulation techniques (eg, patient management problems and role-playing actors), and assessments by colleagues. In employing sophisticated evaluation procedures, objections often are raised concerning the extraordinary effort involved for program designers and the demands placed on physicians. However, with the recurrent mandate for cost-effective CME programs, the use of evaluation

The mean percent of physicians indicating that their practice behavior changed was 60.1 while 35.3 reported no change.

methodology used meets the requirements established by CME accrediting agencies. The strengths of the Wright State University evaluation procedures have been noted. First, data have been collected on a large number of programs. All 37 programs since March 1977, have included pre/post test of knowledge gain, and all 20 programs since February 1979, have included three- to six-month follow-up surveys of change in practice behavior. Second, the dual approach to measuring participant benefit — pre/post test of knowledge gain and follow-up of change in practice behavior — allows greater confidence to be placed in the results than if only a single method had been used. Third, the technique of asking participants to cite specific examples of change in practice behavior due to program participation has served as a validity check on self-report data.

Nevertheless, the authors recognize the need to improve evaluation techniques consistent with the suggestions of Bertram and Brooks-Bertram,¹ Lloyd and Abrahamson,³ and Stein.⁵ In developing evaluation methods for assessing participant learning and change in practice behavior, CME program designers should employ and refine the variety of procedures which have been mentioned throughout this paper. Among appropriate evaluation methods are pre/post tests, practical tests of skills, medical audits, referral

methodology appropriate to the task can no longer be overlooked.

(References and Table 3 are listed on page 418)

Dr. Markert, Dr. Barton and Dr. Rodin are in the Department of Postgraduate Medicine, Wright State University.



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Table 2
Results of McNemar Test Used to Examine Effectiveness of 37 CME Programs in Increasing Knowledge

		Group Mean \geq 70% Before Program			
		No	Yes	No	Yes
Group Mean \geq 70% After Program	Yes	13 (A)	2 (B)		
	No	22 (C)	0 (D)		
χ^2	=	$\frac{[(A - D) - 1]^2}{A + D}$			
		with $df = 1$			
χ^2	=	$\frac{[(13 - 0) - 1]^2}{13 + 0}$			
χ^2	=	11.08			
p	<	.001			



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Table 3
Change/No Change in Practice Behavior for 20 Continuing Medical Education Programs

	Change in Practice Behavior (%)	No Change in Practice Behavior (%)
1 Renal Stones	45*	50*
2 Infectious Diseases	68	32
3 ENT for the Primary Care Physician	76	24
4 Preventive Sports Medicine	78	10
5 Alcohol Prevention	42	42
6 Pain III	72	9
7 Pediatric Review	53	35
8 Gastroenterology Update	52	34
9 Comprehensive Health	64	21
10 Cancer Surgery	71	29
11 Nonproductive Pregnancy in the First Trimester	45	55
12 Anaerobic Infections	78	22
13 Law and Ethics in Medicine	50	50
14 Modern Concepts of Aerospace Activities	25	75
15 Clinical Oncology for Primary Care Physicians	60	40
16 Nutrition	58	42
17 Sports Medicine II	57	43
18 Diagnostic and Statistical Manual of Mental Disorders III	79	21
19 Geriatric Medicine	76	23
20 Current Approaches to Developmental Problems	52	48
MEAN	60.1	35.3

*Responses from retired physicians were not included; thus, totals of change and no change do not equal 100%.

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Look-alike drugs: Medicine's newest headache

The pills are called "look-alike" drugs, or imitation controlled substances, and their manufacture and sale are creating serious problems for state and federal officials, medical personnel, and especially the unwitting victims who've suffered strokes or died after consuming counterfeit drugs.

They're called "look-alikes" because they mimic the size, shape, and color of controlled substances — usually amphetamines or tranquilizers — and may even feature identical trade markings, so they're indistinguishable from the real thing.

The typical "look-alike" stimulant contains a combination of phenylpropanolamine, caffeine and ephedrine, or caffeine alone. Both phenylpropanolamine (an appetite suppressant and nasal decongestant) and ephedrine (a nasal decongestant) increase the heart rate and raise blood pressure. When taken in a high enough dosage or by an extremely sensitive individual, a stroke may result.

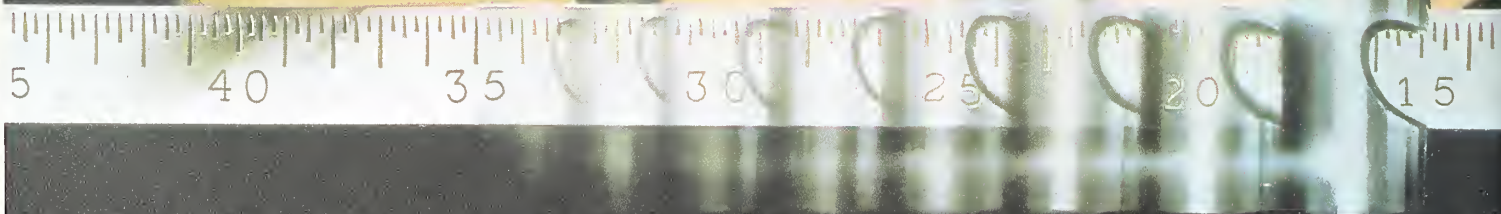
Although the amount of each ingredient varies among manufacturers, a typical "look-alike" has up to 200 milligrams caffeine, 50 to 75 milligrams phenylpropanolamine and 30 milligrams ephedrine. According to the U.S. Food and Drug Administration (FDA), these are the only drugs on the market containing all three ingredients and their combined effect is unpredictable.

While most of the "look-alike" drug trade centers around stimulants (the most popular imitate Fastin, Ionamin, Biphedamine and Dexamyl), tranquilizers such as Dilaudid and Quaalude are also being counterfeited. The phony "downers" contain one or more antihistamines, ingredients found in sleep preparations and cold tablets. Since antihistamines tend to make one drowsy, the user actually may feel sedated — and/or mellow — after consuming the counterfeits.

According to *AMA Drug Evaluations* (a clinical guide to drugs), "Antihistamine overdosage may be difficult to treat. In children, symptoms resemble atropine

(continued on page 425)

Although weight loss achieved in a weight control program varies from patient to patient, this simulated sequence of a professional model illustrates dramatically the benefits of a successful weight loss program.



getting there...

R_x Potent Appetite Suppression

Tenuate^{*} Dospan^{*} ^{IV} _C **(diethylpropion hydrochloride USP)**

75 mg controlled-release tablets

A useful short term adjunct in an overall weight loss program

The anorectic effectiveness of diethylpropion hydrochloride is well documented. No less than 17 separate double-blind, placebo controlled studies attest to its usefulness in daily practice. (Citations provided on request.)

Comparison of Anorectics

	Agent	Amine Classification	Half-life ^a	Variety of Dosage Form	Degree of CNS Effects
Low Abuse Potential	Diethylpropion	Tertiary	4-6 hrs.	25 mg tablet, 75 mg controlled-release tablet	Mild euphoria, mild stimulation
	Mazindol	Nonphenylethyl-amine	33-55 hrs.	1 & 2 mg tablet	Mild euphoria, mild stimulation
	Fenfluramine	Secondary	10-30 hrs.	20 mg tablet	Moderate sedation (mild to moderate depression, a side effect, is also sometimes designated as a CNS effect)
	Phentermine	Primary	19-24 hrs.	8 & 37.5 mg tablet, 8, 15 & 30 mg capsule 15 & 30 mg capsule (resin complex) 15 & 30 mg timed release capsule	Mild euphoria, moderate stimulation
High Abuse Potential	Phenmetrazine	Secondary	7-9 hrs	25 mg tablet, 50 & 75 mg prolonged action tablet	Marked euphoria, marked stimulation
	Amphetamine	Primary	10-30 hrs.	Various	Marked euphoria, marked stimulation

^aDelayed release characteristics of certain dosage forms must also be taken into account.

The #1 prescribed anorectic

Merrell Dow

See Prescribing Information on the next page before prescribing Tenuate.

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Tenuate®^{IV}
(diethylpropion hydrochloride USP)

Tenuate Dospan®^{IV}
(diethylpropion hydrochloride USP)

controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma, agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle, the patient should therefore be cautioned accordingly. When central nervous system active agents are used, consideration must always be given to the possibility of adverse interactions with alcohol. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression, changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride) One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release. One 75 mg. tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of June, 1980

Reference: 1. Abramson R, Garg M, Cioffari A, and Rotman PA. An Evaluation of Behavioral Techniques Reinforced with an Anorectic Drug in a Double-Blind Weight Loss Study. *J Clin Psych* 41:234-237, 1980.

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Obituaries



ARTHUR DORNER, M.D., Paradise Valley, Arizona; Case Western Reserve University School of Medicine, 1927; age 81; died February 11, 1982; member OSMa and AMA.

DWIGHT FRITZ, M.D., Dayton; Ohio State University College of Medicine, 1928; age 77; died March 21, 1982; member OSMa and AMA.

CATHERINE JARCHOW, M.D., Mentor; Case Western Reserve University School of Medicine, 1956; age 60; died January 13, 1982; member OSMa and AMA.

SIDNEY L. MARVIN, M.D., Mantua; Case Western Reserve University School of Medicine, 1946; age 60; died February 27, 1982; member OSMa and AMA.

MELVIN OOSTING, M.D., Ft. Meyers Beach, Florida; Northwestern University Medical School, 1936; age 72; died March 20, 1982; member OSMa and AMA.

JAMES J. PAMPUSH, M.D., Cleveland; St. Louis University School of Medicine, 1946; age 60; died March 26, 1982; member OSMa and AMA.

BEDFORD RIDDLE, M.D., Stow; Howard University College of Medicine, Washington, D.C., 1927; age 83; died March 27; member OSMa and AMA.

STEPHEN SINCLAIR, M.D., East Liverpool; University of Pittsburgh School of Medicine, 1945; age 67; died March 18, 1982; member OSMa and AMA.

NICHOLAS THOMPSON, M.D., Dayton; University of Cincinnati College of Medicine, 1943; age 65; died January 6, 1982; member OSMa and AMA.

ANTOINETTE TITCHENER, M.D., Cincinnati; Duke University School of Medicine, Durham, 1949; age 60; died March 30, 1982; member OSMa.

stimulation of the central nervous system appear alternately. Cardiorespiratory collapse and death may occur."

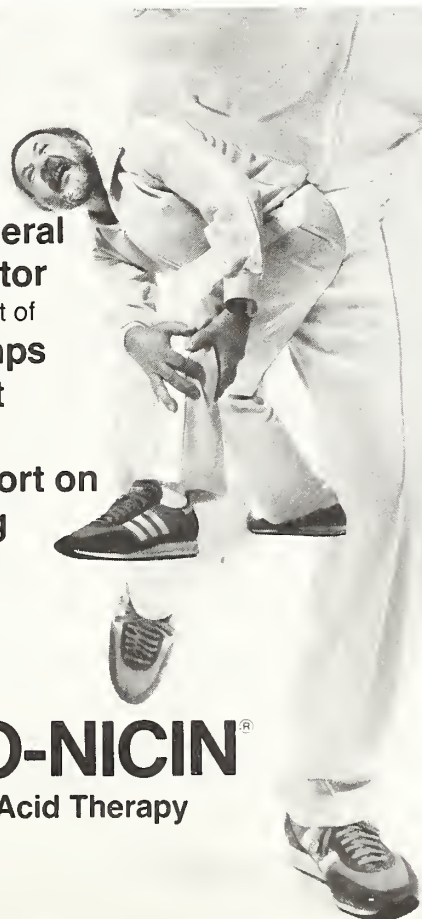
Teenagers who use "look-alikes" often take them with alcohol, a dangerous combination that may have fatal consequences. An even more insidious danger exists for the person who's been using the phony drugs in modest amounts and then unknowingly takes the real thing. If he experiences mild euphoria after taking three or four fake "black beauties," an equivalent number of true Biphentamine-20s will cause intense excitation.

Although touted as "100 percent legal" by those in it, the counterfeit drug industry is not operating entirely within the law. Manufacturers of "look-alikes" maintain they do nothing illegal since the drugs are labeled in compliance with FDA regulations. But when a manufacturer intentionally produces a drug to look exactly like a controlled substance, and the manufacturer is not licensed to produce the controlled substance, he may be prosecuted for violating the counterfeiting provision of the Federal Food, Drug and Cosmetic Act.

Look-alike drugs (continued)
poisoning (excitation, convulsions) and in adults, both depression and

A peripheral vasodilator
for treatment of
leg cramps
cold feet
tinnitus
discomfort on
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LIPO-NICIN®
Nicotinic Acid Therapy



For patient's comfort/convenience
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Gradual Release **LIPO-NICIN®/300 mg.**

Each time-release capsule contains:
Nicotinic Acid 300 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
in a special base of prolonged therapeutic effect.
DOSE: 1 to 2 tablets daily.

AVAILABLE: Bottles of 100, 500.

Immediate Release **LIPO-NICIN®/250 mg.**

Each yellow tablet contains:
Nicotinic Acid 250 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

LIPO-NICIN®/100 mg.

Each blue tablet contains:
Nicotinic Acid 100 mg.
Niacinamide 75 mg.
Ascorbic Acid 150 mg.
Thiamine HCL (B-1) 25 mg.
Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 5 tablets daily.

AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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FAMILY MEDICINE REVIEW: June 14-18; Marriott Inn North, Columbus; 40 credit hours; sponsor: Ohio Academy of Family Physicians; fee: \$250 physicians, \$100 for residents; contact: Mrs. Florence I. Landis, 4075 N. High Street, Columbus 43214, phone: 614/267-7867.

IMPORTANT ISSUES AND DEVELOPMENTS: OBSTETRICS, GYNECOLOGIC INFECTIONS, AND INFERTILITY: August 6-8; Kings Island Inn and Conference Center, Mason; 18 credit hours; sponsor: University of Cincinnati Medical Center; fee: \$350, \$250 for physicians in training; contact: Norma Mason, Department of OB/GYN, University of Cincinnati Medical Center, 231 Bethesda Avenue, Cincinnati 45267, phone: 315/872-4687.

ANTERIOR AND POSTERIOR VITRECTOMY WORKSHOP: August 6-7; The Terrace Hilton Hotel, 15 West 6th Street, Cincinnati; 16 credit hours; sponsor: Bethesda Hospital and Deaconess Association, Cincinnati; fee: \$500, \$250 for residents; contact: Thomas O'Connor, Bethesda Hospital, 619 Oak Street, Cincinnati 45206, phone: 513/559-6337.

ANNUAL SCIENTIFIC ASSEMBLY: August 6-8; Stouffer's On The Square, Cleveland; 13 credit hours; sponsor: Ohio Academy of Family Physicians; no fee; contact: Mrs. Florence I. Landis, 4075 N. High Street, Columbus 43214, phone: 614/267-7867.

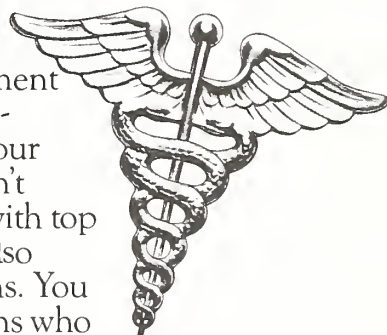
12TH ANNUAL PERIPHERAL VASCULAR DISEASE SYMPOSIUM: September 9, 10, 11; University Hilton Inn, Columbus; 17 credit hours; sponsor: Saint Anthony Hospital, Columbus; fee: \$250; contact: Pat McGlone, 1450 Hawthorne Avenue, Tower 11, Columbus 43203, phone: 614/251-3680.

DISEASES OF THE EAR: September 10-11; Stouffer's Cincinnati Towers; 14 credit hours; sponsor: Bethesda Hospital, Cincinnati; fee: \$145; contact: Thomas O'Connor, Bethesda Hospital, 619 Oak Street, Cincinnati 45206, phone: 513/559-6337.

1982-83 CORE CONTENT REVIEW OF FAMILY MEDICINE: September 1982 - April 1983 monthly; Correspondence Course; sponsor: Ohio Academy of Family Physicians, 32 credit hours; fee: \$95, \$115 nonmembers, \$40 for residents; contact: Mrs. Florence I. Landis, OAFP, 4075 North High Street, Columbus 43214, phone: 614/267-7867.

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BOOK SHELF

Womancare, Backcare and Heartcare are the first three volumes to launch the American Medical Association's Health Library. They are \$12.95 each.

These first three consumer trade volumes are geared toward individual self-education and preventive care. Based on a consensus of the most recent medical opinion from consultants all over the country, these books demonstrate the premise that knowledge in itself is preventive care.

These volumes contain specific information and advice that is sound, sensible and safe in three specialty fields where advice, in the past, has often been confusing.

For further information on any of these volumes, contact Random House, 201 East Fiftieth St., New York, N.Y. 10022.

AMA Publications . . . Therapeutic Claims . . . Diet Modification

Therapeutic Claims in Multiple Sclerosis. *International Federation of Multiple Sclerosis Societies.* \$7.00

In this volume, 120 therapies are evaluated by an international team of neurologists with long experience in treating multiple sclerosis patients.

As they point out, few of the 120 claims actually help the patient overcome the symptomatic problems associated with MS, however, many of them are being offered at the present time as "cures."

Researchers have found that multiple sclerosis is associated with an abnormality in immune response, possibly triggered by a latent virus. The MS Society is funding extensive research which offers insight into the disease process and ways of reversing it, but false therapeutic claims, the book says, can only cause further pain to patients, their families and friends. Not only are hopes raised in vain, but often considerable expense is involved

and the side effects of some of the treatments become yet another issue.

The book can be ordered from the National Multiple Sclerosis Society, 205 E. 42nd Street, New York, N.Y. 10017.

The current scientific evidence does not justify advising healthy people to modify their diets in an effort to prevent coronary heart disease (except for recommending weight reduction for obese individuals), says the American Council on Science and Health (ACSH).

The Council, an independent scientific organization, first examined the relationship of diet to heart disease two years ago. In the new edition of the report, **Diet Modification: Can It Reduce the Risk of Heart Disease?**

Copies of the new edition of **Diet Modification: Can It Reduce the Risk of Heart Disease?** can be obtained from ACSH, 47 Maple St., Summit, NJ 07901. Phone: 201-277-0024.

Q's & A's about the OSMA Group Professional Liability Plan (continued)

Current PICO policyholders will automatically be enrolled in the Plan, with all the benefits including lower premiums, at the renewal dates of their current policies. For PICO policyholders who renew in May or June, 1982, their coverage will be renewed at present rates until July 1, when the new Plan rates will automatically take effect. For those PICO policyholders who renew after July 1, they will become participants in the Plan, at the reduced premiums, as they renew their coverage.

Your excess coverage will continue as before and will be renewed on the renewal date of the current policy.

What if I am not presently a PICO policyholder, but wish to participate in the Plan?

Prior to the expiration date of your present policy, simply contact the OSMA. After approval of your application, you will be enrolled in the Plan.

Who is eligible to participate in the OSMA Group Plan?

You are an eligible physician if you:

Are a member of the Ohio State Medical Association.

Are licensed by the Ohio State Medical Board.

Practice the majority of time in Ohio.

Meet the Plan's underwriting requirements.

What are the particular advantages of "group" professional liability coverage?

As indicated above, you receive lower rates because of the administrative savings of a group plan.

Additionally, the master policy issued to the OSMA by PICO includes a profit sharing agreement that enables the policyholder (the OSMA) to share in any future profits from the total business volume of the Plan, including income from investment of premiums.

The OSMA and PICO will review, annually, all credits to the Plan (premiums and investment income) and charges to the plan (expenses and claims). Any indicated rate adjustments will be discussed thoroughly by the OSMA and PICO prior to implementation by mutual agreement.

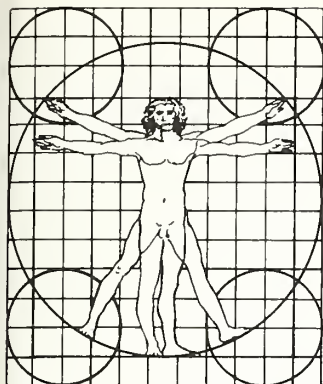
How do I find out more about the OSMA Group Professional Liability Plan?

For more information, call Mr. Jerry Campbell at the Ohio State Medical Association, at (614) 228-6971.

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Physician of the Year

DUDLEY F. BRIGGS, M.D., Columbus, was named Physician of the Year for 1981 by the President's Committee on Employment of the Handicapped. Dr. Briggs is the medical director of Western Electric's Columbus Works, and a clinical assistant professor at Ohio State University. He has written numerous articles for medical magazines and is presently a literature reviewer for the *Journal of Occupational Medicine*.



CLINICAL & SCIENTIFIC

PERCUTANEOUS TRANSLUMINAL CORONARY ANGIOPLASTY: AN EARLY OVERVIEW (PART I)

Ralph D. Lach, M.D.
Wayne L. Beaver, M.D.

Internal "remodeling" of atherosclerotic arteries has been perfected since its inception in 1964. After extensive application to peripheral arteries, the procedure has now been achieved in a significant number of patients with coronary artery disease, identifying a subset who may be treated safely and with good long-term results through a percutaneous catheter approach. Acceptably low rates for morbidity, mortality and restenosis have been attained with evidence that these figures should progressively improve further.

IN THE JOURNAL CIRCULATION in 1964, Dr. Charles Dotter and Dr. Melvin Judkins, described a technic for what they referred to as "Transluminal Treatment of Arteriosclerotic Obstruction."¹ This revolutionary and ingenious concept for the treatment of atherosclerotic obstruction was based on the use of a "coaxial" recanalization technic. This meant that a high-grade obstruction which could be traversed by a very fine wire, then could be dilated by the passage of successively larger catheters over the initial guidewire. Dilation of iliac and femoral arteries to a 12F dimension was undertaken in hundreds of cases. As this technic was attempted by more investigators, it was felt that certain difficulties might be encountered because of the shearing forces of the catheter which might displace the atheromatous material to a more distal position in the artery, either obstructing the main vessel, or possibly one of its side branches.

In 1974, Andreas Gruntzig, M.D., of Zurich, introduced a major modification of this transluminal approach.² He developed a balloon catheter which could be placed in the region of the maximum stenosis and distended with a fluid medium in a

fashion to "remodel" the vessel by compression of the atheromatous material against the wall. This approach was used by Gruntzig for peripheral dilations in over 200 patients by September 1977. In the meantime, Gruntzig had done painstaking experimental work on post-mortem and animal preparations to achieve definitive proof that the procedure (1) could dilate an atherosclerotic obstruction; (2) would not injure the artery; and (3) would not cause fragmentation emboli to be dislodged into distal vessels.

Because of the coronary anatomy, Gruntzig also had to develop a system of "guiding" catheters which would deliver the dilating balloon to the appropriate coronary vessel (see Fig. 1).

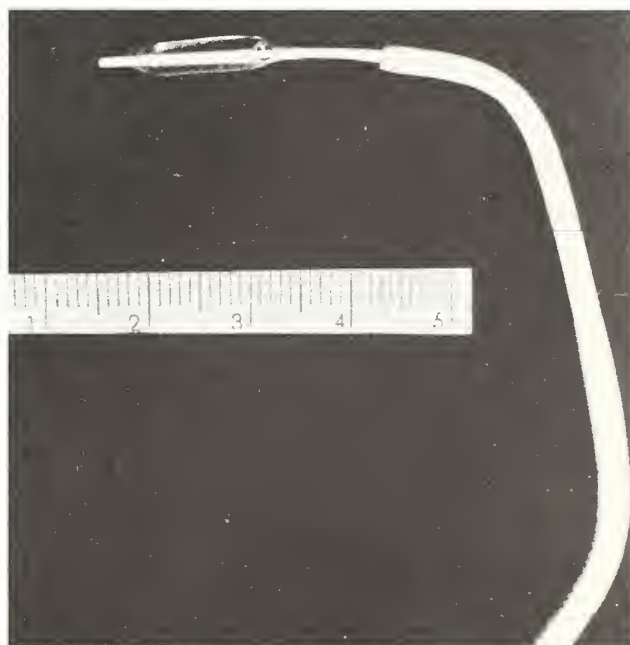


Figure 1 — The Gruntzig balloon dilation catheter emerging from the top of a "guiding catheter." (Repr. by perm. Georg Thieme Verlag)

Dr. Lach, Columbus, Chief, Division of Cardiology and Principal Investigator, PTCA Project, Mount Carmel Medical Center, and Clinical Assistant Professor, Division of Cardiology, Ohio State University College of Medicine.

Dr. Beaver, Columbus, Attending Cardiologist, and Co-Investigator, PTCA Project, Mount Carmel Medical Center. Submitted March 3, 1981.

In the summer of 1977, at the time of aortocoronary bypass surgery, Gruntzig inserted his balloon catheter retrograde from the site of the distal coronary arteriotomy which was to be used for the saphenous bypass. Dilation of the proximal coronary stenosis was performed and the effluent was collected in a millipore filter. No evidence of embolic material was discovered in the six patients so treated. In September 1977, Gruntzig performed the first human percutaneous transluminal coronary angioplasty (PTCA) (see Fig. 2).

Following Gruntzig's work, similar procedures were performed in Frankfurt, San Francisco, and New York. The international experience with this technic approached 750 patients. The technic was still considered to be purely investigational. In the United States, a research protocol under the supervision of the Food and Drug Administration was carried out in the following centers:

NHLBI - PTCA REGISTRY
CONTRIBUTING CLINICAL SITES

Rhode Island Hospital
Milwaukee Lutheran Hospital
Medical College of Pennsylvania
Saint Mary's Hospital, San Francisco, California
National Heart, Lung and Blood Institute
Stanford University Hospital
Saint Joseph's Hospital, Atlanta, Georgia
Medical College of Virginia
Massachusetts General Hospital, Boston, Massachusetts
Lenox Hill Hospital, New York City
Albany Medical College
University of Massachusetts
Hospital of the University of Pennsylvania Medical Center
Dr. David M. Bratman, Memorial Hospital,
Culver City, California
Long Island Jewish Hospital
Mayo Clinic
Mount Carmel Medical Center, Columbus, Ohio
University of California - Davis

Uniform patient selection criteria, materials and follow-up evaluation were required. Tabulation of results was overseen

by the staff of the National Heart, Lung and Blood Institute of the National Institutes of Health.

Investigational Protocol (Adapted after Gruntzig)

1. *Clinical History.* — Recent onset angina, relatively refractory to medical therapy with nitrates and beta blockade, compromised quality of life, candidate for coronary artery bypass surgery.

2. *Coronary Anatomy.* — Discrete, subtotal, noncalcified lesion of a major coronary artery. Stenosis less than one centimeter in length with patent distal vessel.

3. *Pathophysiology.* — Positive exercise test and/or positive exercise thallium scan.

4. *Preparation.* — Full informed consent is obtained after explanation of the pathology, procedure, complications, and alternative forms of therapy. Surgical consultation is obtained to assure that the patient is adequately prepared for surgery and that the surgical team is involved in the procedure on a "standby" basis.

5. *Technic.* — The femoral artery is prepared as it is for routine coronary angiography. (The brachial approach also may be used.) A standard coronary arteriogram is obtained to assure that the previous arteriographic findings have not changed since the patient was referred for PTCA. The appropriate guiding catheter then is placed at the ostium of the subject vessel and a dilating catheter is advanced with positioning of the balloon in the region of the coronary stenosis. The fluid-filled balloon is then inflated for approximately five to ten seconds and this inflation is repeated. Repeat selective arteriogram is performed to assess the status of the dilated vessel. Intracoronary pressure is monitored throughout the procedure, both through the guiding catheter (central aortic pressure proximal to stenosis) and the dilating catheter (poststenotic or distal pressure).

6. *Follow-up.* — Thallium exercise testing within one week after PTCA and at six monthly intervals. Repeat coronary angiography at three to six months. Anticoagulant regimen is maintained for at least six months.

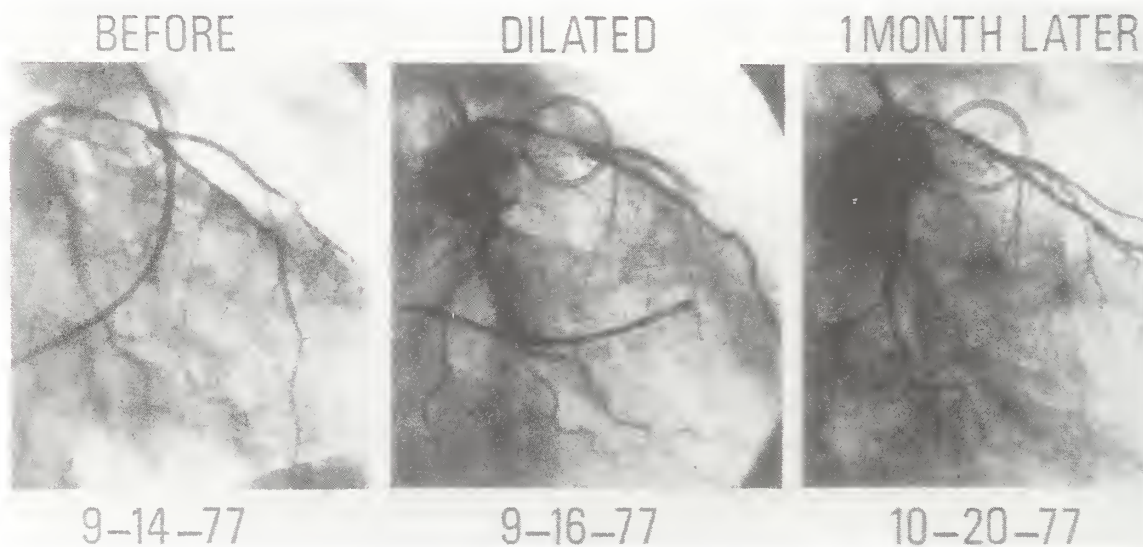


Figure 2 — Cineangiographic frame taken from studies done on the first human to undergo PTCA of the left anterior descending coronary artery. (Repr. by perm. of Georg Thieme Verlag)



Figure 3A — The LAO view of right coronary artery (10-25-79)

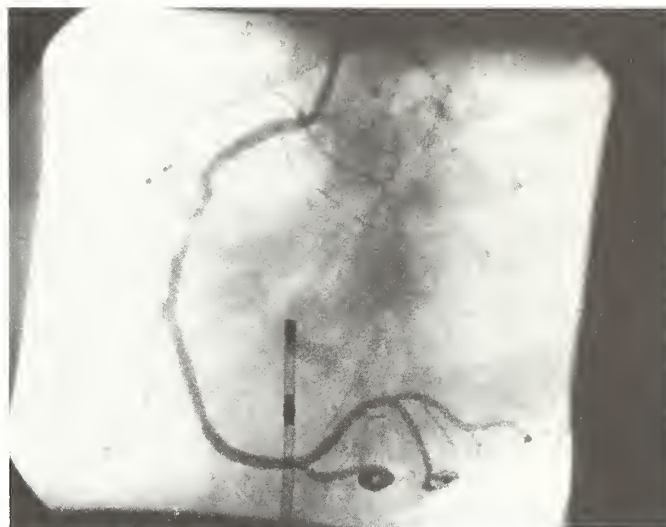
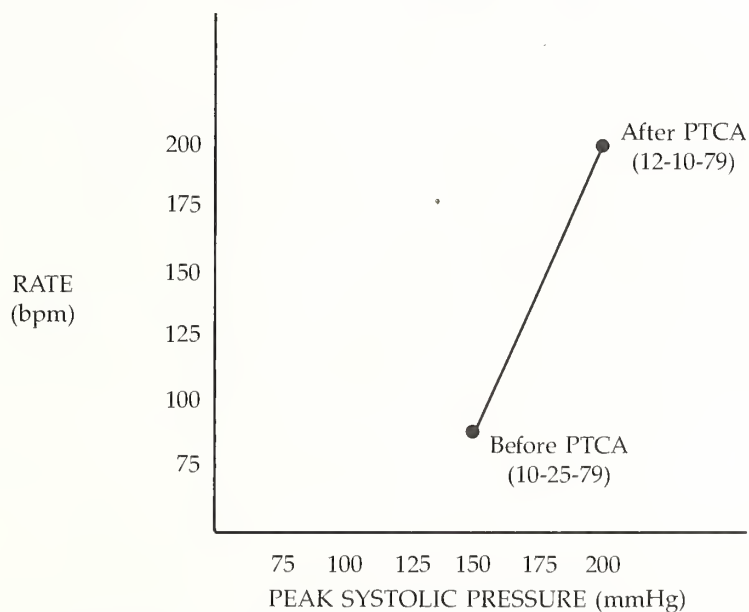


Figure 3B — The RAO view of right coronary artery (10-25-79)

Prior to PTCA, the severely narrowed artery is depicted in 3A and 3B.

Figure 4



Rate pressure response to exercise utilizing the Bruce treadmill protocol. *Before* PTCA, the exercise was terminated because of severe anginal pain at a rate/pressure product of 12,000.

Five days *after* PTCA, the patient reached a rate/pressure product of 36,000 without discomfort and the exercise was terminated because he had exceeded the 90% predicted maximal heart rate.



Figure 5A — Gruntzig dilating catheter in place across the stenosis with marker electrodes at either side.

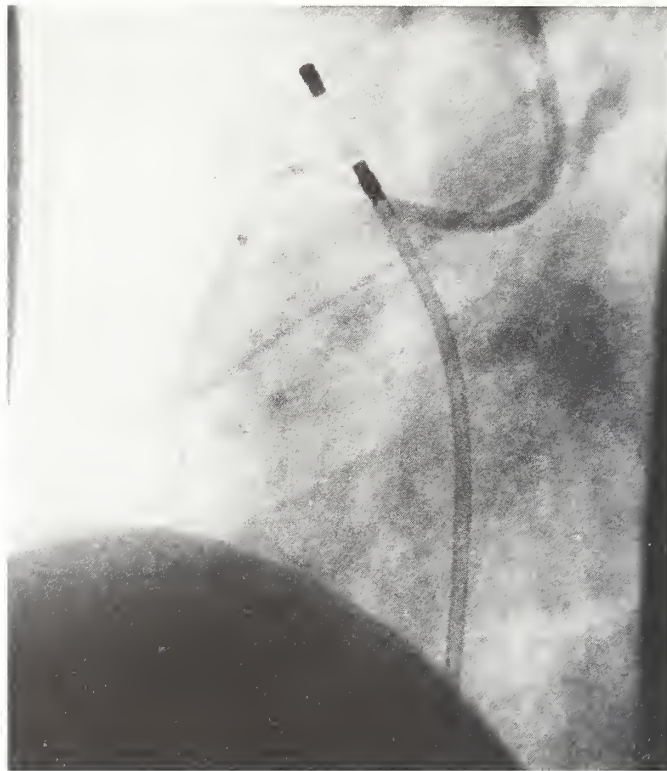


Figure 5B — Gruntzig dilating catheter in place with dilute contrast distending the balloon between the two marker electrodes. A standard atrial pacing catheter is in the high right atrium.



Figure 6 — View of the right coronary artery taken after dilation (12-5-79). Note the restoration of the lumen diameter.



Figure 7A — The LAO view of right coronary artery (3-25-80)

The right coronary artery as seen during the follow-up catheterization (3-25-80) in the LAO and RAO views with persistent relief of the stenosis.

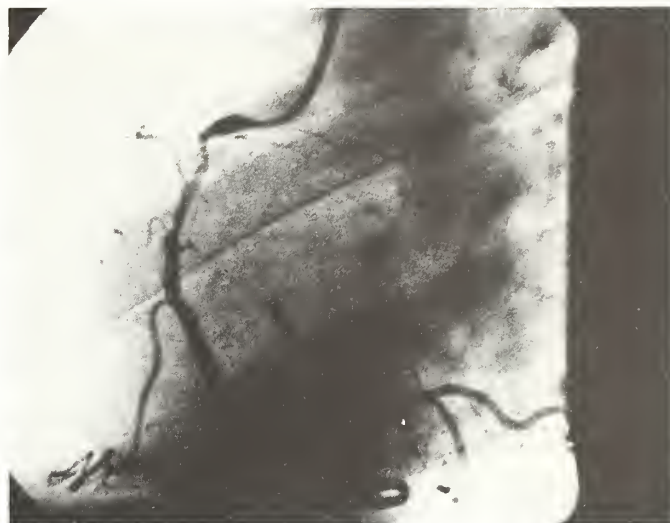


Figure 7B — The RAO view of right coronary artery (3-25-80)

Related Miscellaneous Considerations

1. Various anticoagulant regimens are being evaluated. Heparin, dextran, warfarin, aspirin and dipyridamole are being utilized.

2. Calcium antagonists (slow-channel blockers) are used widely in Europe and have proven beneficial to the reduction of coronary spasm at the time of PTCA. Some investigational protocols include the use of these agents and it is anticipated that at least some of these drugs will be available in the United States within the next 12 months.

3. During the investigational phase, the selection criteria mentioned above will limit the number of candidates for PTCA to 5% of the cohort recognized as candidates for coronary artery bypass graft surgery.

4. Left main coronary stenosis and stenosis of saphenous bypass grafts will not represent prime indications for PTCA at the present time, due to less than ideal results in the early stages of investigation in those lesions.

On March 28, 1980, the Food and Drug Administration approved the general application of the PTCA procedure considering that the evaluation of the dilating catheters of one of the manufacturers was adequate. The indications for the procedure are essentially as had been delineated in the investigational protocol previously cited, although some latitude is provided.

The anatomic and physiologic responses to PTCA in a 51-year-old white male with recent onset angina pectoris are depicted in Figures 3 through 7.

It is possible the Gruntzig technic of PTCA will revolutionize the practice of cardiology for the following reasons:

1. There is evidence that 60% to 80% of these patients will experience significant relief of obstruction and symptoms for at least a significant period of time. It seems likely that the results will closely parallel those of peripheral vascular dilation, ie, 70% patency over five years.

2. Even with the restrictive selection criteria, at least 3,000 to 5,000 Americans will be spared the morbidity and expense of coronary artery bypass surgery annually.

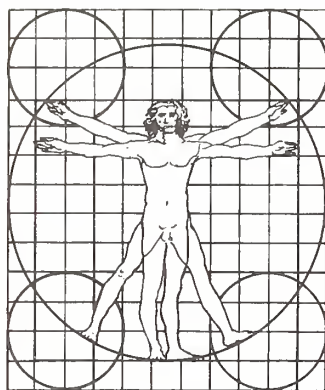
3. The nature of the coronary arterial lesion now will be studied from an entirely new perspective. Already, those who have performed significant numbers of angioplasties have seen a frequent phenomenon of progressive "healing" of the atheroma over the months following dilation. That is to say that, even when a residual stenosis is left after PTCA, repeat angiography six months later shows further diminution or disappearance of that stenosis.

4. Even now, the application of this technic is being extended, particularly by the work of Rentrop,⁴ who has attacked the obstructive lesion in the setting of early myocardial infarction with at least some initial success.

Finally, one must recognize the current paradox of PTCA, by which the application of this procedure is denied individuals with less than extremely severe stenosis. This, in turn, militates against the likelihood of neogitating the dilating catheter across the obstruction. If the safety and efficacy of PTCA is proven in these "extreme" cases, then one might project the application of PTCA to less than extreme situations, increasing the likelihood of success.

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CLINICAL & SCIENTIFIC

NONINVASIVE CAROTID ARTERY EVALUATION

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Robert K. Betts, B.S.E.E.

Extracranial carotid occlusive disease is responsible for some of the morbidity and mortality resulting from strokes. Noninvasive testing provides a way to detect, quantitate and follow carotid occlusive disease. It is safe, painless, reliable, accurate, relatively inexpensive and can be repeated. The overall accuracy of OPG/CPA is 90%. The need for arteriography in patients with hemispheric symptoms should not be influenced by this test. Performance and interpretation require experience and must be in the hands of qualified and competent personnel.

DUE TO THE INCREASING age of our population, arteriosclerosis-related morbidity and mortality will continue to rise. It is estimated that strokes kill more than 275,000 and disable another 350,000 United States citizens. The annual expenditure for medical care and lost wages totals more than \$4 billion a year. In contrast to other stroke-causing entities, extracranial carotid occlusive disease has the potential for being detected and treated before the occurrence of a debilitating neurologic deficit. Occlusive disease generally involves the cervical carotid bifurcation and the first few centimeters of the internal carotid artery. Since the latter is not easily accessible to physical examination, most noninvasive methods evaluate the carotid circulation in an indirect fashion by focusing on the ocular pulse wave form resulting from expansion of the globe. Audio frequency analysis of carotid bruits, ophthalmodyna-

mometry, facial thermography and directional Doppler ultrasonography are other available technics. Direct noninvasive carotid imaging technics such as pulse Doppler and real-time B mode echo arteriography currently are being refined for use.

The ideal carotid noninvasive study should be safe, inexpensive, reliable, reproducible, and have a high patient acceptability.¹ Carotid phonoangiography (CPA) and fluid-filled oculoplethysmography (OPG, Kartchner)² together fulfill all these criteria. Our experience with this technic in a community hospital setting is presented.

OPG and CPA. — Carotid phonoangiography aids in the noninvasive evaluation of extracranial carotid bruits. A bruit is caused by turbulent blood flow distal to an arterial stenosis and can be quantitated according to the degree of stenosis. A special hand-held microphone detects cervical bruits which are heard through a headset. The sound is displayed on an oscilloscope and a permanent record is obtained by an attached Polaroid camera. Tracings then are obtained above, at, and below the carotid bifurcation to help determine the site of origin of the bruit. Occasional difficulty may be encountered in patients with severe respiratory disorders who may have trouble holding their breath. Bruits from carotid bifurcation stenosis are higher pitched and are of longer duration at the angle of the jaw than at the base of the neck. Since the wave form amplitude is dependent on proper microphone placement, amplitude is not important in determining bruit significance. The internal carotid artery has a high level of diastolic blood flow in contrast to the external carotid, in which bruits generally occur during systole. Therefore, a diastolic bruit heard over the carotid bifurcation indicates severe internal carotid stenosis. It also is pertinent to note that greater than 85% to 90% stenosis may result in absence of a bruit.

Oculoplethysmography obtains ocular pulse tracings by means of 12 mm saline-filled eye cups applied directly over the cornea after application of a local anesthetic. Photoplethysmographic clips are placed over both ear lobes to reflect the external carotid artery circulation. Both eye pulses, the right ear pulse, and an electronically calculated "differential" tracing all are simultaneously recorded. The ocular pulse is a manifestation of the negative pressure exerted when the cornea is withdrawn from the cup as the globe expands with each arriving arterial pulse. Hemodynamically significant internal carotid stenosis with flow reduction of greater than 20% is indicated by a visible delay of one or both ocular pulses in comparison to

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Submitted April 10, 1981.

each other or the ear pulse. In addition, the differential line may be shifted to indicate left- or right-sided stenosis. The eye cups then are crossed to verify the findings of the direct study. The test is performed with the patient sitting, although in a cooperative patient it can be performed supine. Less than 30 minutes usually are required for both CPA/OPG testing.

Results of the Study. — A prospective evaluation of the accuracy of combined OPG/CPA compared to angiography was carried out in the peripheral vascular laboratory at Grant Hospital. In the 12-month period ending October 1980, over 800 OPG/CPA studies were performed. Twenty-seven patients also underwent arch angiography with 44 carotid arteries being available for comparison with noninvasive studies. The mean age of these 27 patients was 63 years with a range of 25 to 87 years. The indications for noninvasive studies were as follows: transient ischemic attacks/strokes (16), nonhemispheric symptoms (6), severe headaches and other nervous system complaints (3), and asymptomatic bruits (2). For purposes of statistical evaluation, a greater than 40% reduction in diameter of the internal or common carotid artery by arteriography was regarded as hemodynamically significant. The sensitivity

$$\left(\frac{\text{Test Positive/True Positive}}{\text{True Positive}} \right)$$

reflecting the ability of the test to detect disease when angiograms were in fact abnormal, was 84.21%. The specificity

$$\left(\frac{\text{Test Negative/True Negative}}{\text{True Negative}} \right)$$

indicating the ability of the test to signify absence of disease when the angiogram was in fact negative, was 96%. The overall accuracy was 90.91%. The percentage of luminal stenosis as seen by angiography was identified to within one grade by OPG/CPA in 84% of the 44 arteries evaluated.

Indications for OPG/CPA. — OPG/CPA is a good diagnostic tool as a screening procedure in stroke-prone patients, ie, patients with generalized arteriosclerosis, those with diabetes mellitus and a family history of cerebral arteriosclerosis (Table 1). Patients with vague nonhemispheric complaints such as dizziness, lightheadedness, bilateral visual disturbances, and syncopal episodes can be screened. Presurgical cerebrovascular evaluation can be valuable in certain patients (Fig. 1). A

baseline study in patients with transient ischemic attacks is often helpful. Noninvasive testing also is useful in detecting recurrent stenosis or contralateral carotid disease following a previous carotid endarterectomy (Fig. 2).

Carotid Bruit Evaluation. — Combined OPG/CPA testing resolves some but not all the questions arising from the detection of an asymptomatic carotid bruit by cervical auscultation. This is particularly a dilemma prior to an elective surgical procedure. Subbifurcational bruits are easily identified and no further subsequent investigation is necessary when the CPA indicates such and the OPG is normal. Bruits classified as showing less than 40% stenosis with a negative OPG (Grade I) can be followed periodically for evidence of progression (Table 2). Kartchner, et al, followed 1,287 patients with asymptomatic bruits for an average of 24 months.² Of the 147 patients with abnormal OPG/CPA, 58.7% required endarterectomy or had strokes, compared to 3.4% of patients with normal OPG/CPAs. Severe external carotid stenosis causing a harsh bruit occurred in about 10% to 15% in this overall category; these are identified on the basis of an ear pulse delay and a normal OPG. Presence of a bruit does not, therefore, necessarily indicate internal carotid stenosis and absence of a bruit does not rule out severe carotid stenosis or total occlusion. Patients with Grade II studies can be retested at six- to twelve-month intervals unless new symptoms occur. Those with a Grade III study should be brought for a repeat study in three to six months to detect progression of stenosis, or angiogrammed, depending on the symptoms. Patients with Grade IV or V lesions are at high risk for stroke and their management is individualized depending on the presence or absence of symptoms and the desire of the physician and patient. It is therefore obvious that OPG and CPA are complementary, and used intelligently, can help limit the number of patients requiring angiography.

Advantages. — Combined OPG/CPA testing satisfies most of the criteria for the ideal carotid noninvasive technic. It is safe and can be performed in the presence of cataracts, glaucoma, hypertension, cardiac arrhythmias, etc. Patients with recent cornea or eye surgery should not be subjected to the OPG until sufficient healing has occurred. Patients accept the test easily since it is painless and no invasive measures are required. No

TABLE 1

INDICATIONS FOR NONINVASIVE CAROTID TESTING

1. Asymptomatic Cervical Bruits
2. Nonhemispheric Cerebral Symptoms
3. Screening For Patients at Risk For Stroke
4. Followup After Carotid Endarterectomy
5. Evaluating Symptomatic Patients For Baseline Testing

TABLE 2

Grade	CPA (Stenosis) %	OPG (Flow Reduction) %	Hemodynamic Significance
1	<40	<20	Negative
2	40-60	20-30	Mild
3	60-70	30-40	Moderate
4	70-85	>40	Severe
5	>85 no Bruit	→100	Very Severe/ Total Occlusion

carotid compression is required. The test can be performed on outpatients also and usually takes no more than 30 minutes. OPG/CPA can spare patients unnecessary arteriography and increase the positive yield. The cost savings in terms of avoiding hospitalization and radiographic procedures are appreciable. The early detection of extracranial carotid occlusive disease provides an opportunity for a reduction in the morbidity and mortality from strokes. Finally, the test is performed by a trained nurse or technician and the interpretation completed by an experienced physician. The interpreting physician does not see the patient unless additional testing is required or clinical correlation is necessary.

Disadvantages. — First and foremost, the study is somewhat observer-dependent and requires considerable experience to interpret. OPG/CPA is an indirect method in contrast to direct imaging of the cervical carotid arteries. Although the overall accuracy is good, the test does not reliably identify hemodynamically insignificant stenosis or ulcerative plaques without stenosis. The accuracy increases as the severity of stenosis increases. Bilateral equally high-grade internal carotid artery stenosis poses a problem sometimes, although by experience these also can be identified. Technical errors in the performance of the tests can produce false positive results. An air bubble in the water-filled system can indicate unilateral stenosis. However, the routine of crossing the eye cups in each patient safeguards against this. The OPG cannot localize the site of stenosis or occlusion and reflects hemodynamically significant stenosis from the arch to the ophthalmic artery. Narrowing of

the latter can give an abnormal result. There are a few patients who cannot sit upright and although OPG testing can be performed supine, it requires patience and is often difficult to interpret. The OPG cannot be used in patients with purulent conjunctivitis and those with recent eye surgery.

To summarize, techniques for noninvasive carotid testing for hemodynamically significant carotid occlusive disease have been refined to give an overall accuracy between 85% to 90%. OPG/CPA is safe, reliable, relatively inexpensive, and accurate. Performance and interpretation must be in the hands of competent and experienced personnel to obtain optimum results. The need for arteriography or surgery in patients with hemispheric symptoms should not be influenced solely by the results of noninvasive studies as ulcerative, nonstenotic lesions are not detected. The potential for abuse of these tests exists, and well-defined criteria for requesting these studies should be adhered to.

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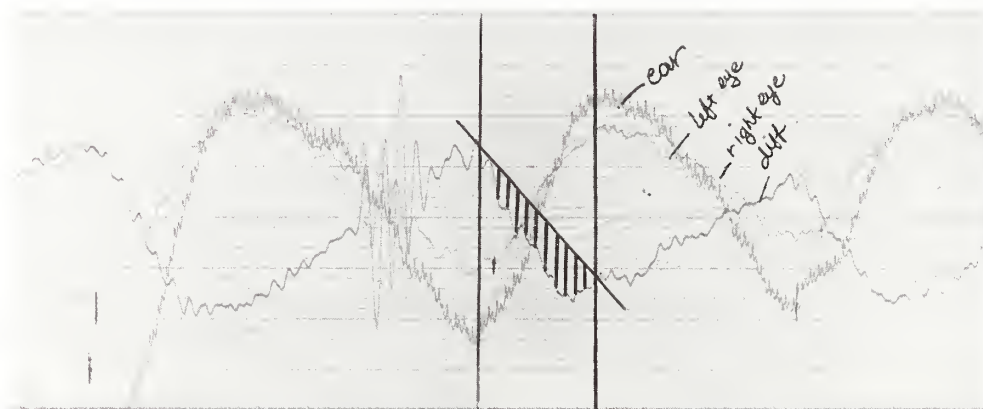


Figure 1: Preoperative OPG Showing Differential Shift (hatched area) with right carotid stenosis.

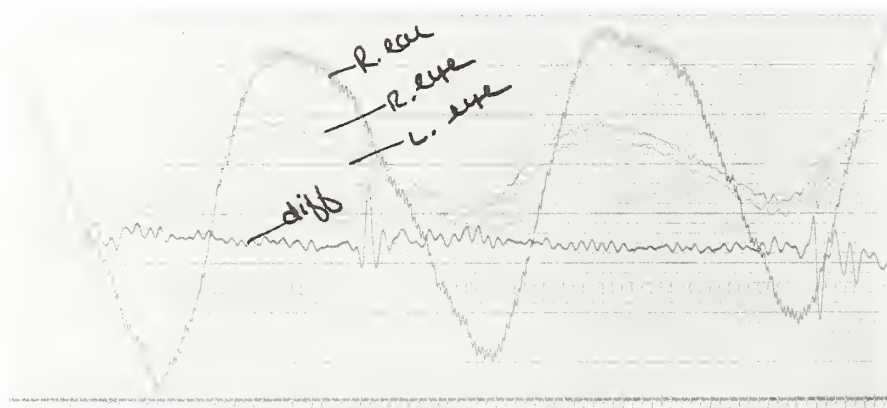


Figure 2: Normal Post Endarterectomy OPG

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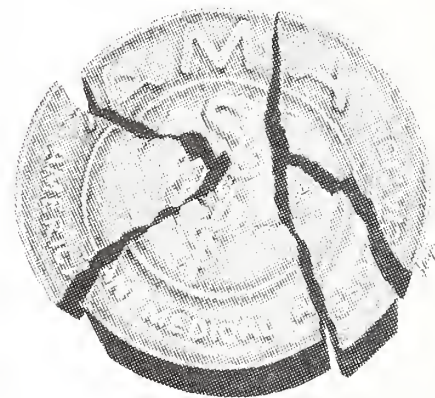
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Indications: Management of anxiety disorders, short-term relief of anxiety symptoms, acute alcohol withdrawal symptoms, preoperative apprehension and anxiety. Usually not required for anxiety or tension associated with stress of everyday life. Efficacy beyond four months not established by systematic clinical studies. Periodic reassessment of therapy recommended.

Contraindications: Known hypersensitivity to drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) reported after abrupt cessation of extended use of excessive doses are similar to those seen with barbiturates. Milder symptoms reported infrequently when continuous therapy is abruptly ended. Avoid abrupt discontinuation; gradually taper dosage.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically. Due to isolated reports of exacerbation, use with caution in patients with porphyria.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction, changes in EEG patterns (low-voltage fast activity) may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety disorders and symptoms, 5 or 10 mg *t.i.d.* or *q.i.d.*, severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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The Ohio State Medical Journal
600 South High Street
Columbus, Ohio 43215
Telephone: 614/228-6971

Address All Correspondence, Address Change, & Reprint Request (unless otherwise noted): Executive Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215. Phone: 614/228-6971.

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1981 Subscription: \$15 per year, single copy \$2 (outside U.S. \$20 and \$3).

Send address changes to: The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second Class Postage paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701

Printed by
The Lawhead Press, Inc., Athens, Ohio

A message from the President . . .

I have been told that some members of our Association believe that the OSMA subsidizes the Physicians Insurance Company of Ohio (PICO) with monies obtained from membership dues.

OSMA's expenditures were listed in the auditor's report published in the September 1982 issue of the OSMA Journal. No such subsidies are listed, since no such subsidies exist.

OSMA provides certain services to PICO for which PICO reimburses OSMA.

It is notable that PICO was established as the result of an action of the OSMA House of Delegates in special session, August 1, 1976. The OSMA-PICO relationship was reaffirmed with the House's action on Resolution 33-82 in May 1982.

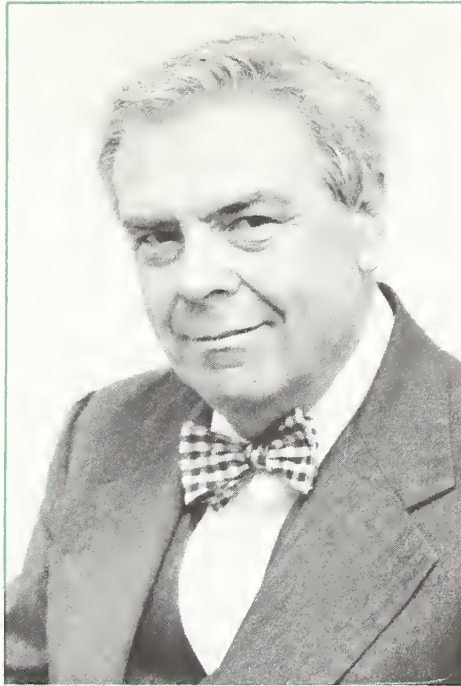
Physicians are aware of the ease in obtaining professional liability insurance today, in contrast to the difficulty experienced in 1975 and 1976. The Association's development and direction of the PICO program has been a significant factor in today's positive professional liability insurance climate and has been of benefit to all Ohio physicians. It continues to be of benefit to all OSMA members whether or not they are insured by PICO.

In summary, PICO is a vigorous insurance company which "stands on its own feet" and it is not supported by OSMA dues.

C. Douglass Ford, President
OSMA

(Please turn to page 443 for Dr. Ford's President's page.)

PRESIDENTIAL PERSPECTIVES



C. Douglass Ford, M.D.

One of the advantages of being President of the Ohio State Medical Association (OSMA), is having the opportunity to develop and expand the list of services which the Association provides its members on an ongoing basis.

Over the past several months, I have been involved in negotiations between the OSMA and the Huntington National Bank for a bank card program which, when put into effect, should help our members protect and improve the cash flow from their practices.

Until now, most of our members have had to negotiate, individually, for bank card processing through their local banks — or they have simply avoided the problem by not accepting bank cards as payment.

The Huntington Bank, however, is willing to process all bank card transactions for OSMA members at a flat rate of 2.75% of the monthly gross sales volume — a rate which is not only guaranteed for one year, but is certainly one of the most reasonable rates available.

Each member who participates in the bank card program must have a Huntington business checking account which will be subject to the same service charges as a normal checking account, and will require a \$10 deposit to open. However, both MasterCard and Visa transactions can be deposited together in one account, and will be given same-day availability.

Members who are located in a Huntington service area will deposit

locally at the nearest Huntington office. Those who are not located in a Huntington service area will mail their deposits to Columbus for immediate credit. The fee for processing bank card transactions will be debited from the member's checking account each month.

As this program is a benefit of membership, only those physicians who are members and located in Ohio — are eligible to participate. By the time you read this, the project already will be well underway. Watch the Journal and the OSMAgram for future developments on this project. The bank card program is just one more way your Association tries to help you in your practice.

Credit cards

OSMA takes a step to help ease the age-old problem of cash flow.

A word about the participating agreements being offered by OMIM. You should know that your Association and its leaders can neither support nor oppose this plan without incurring increased exposure to a lawsuit. I believe that Ohio's physicians are perceptive enough to weigh the advantages and disadvantages the plan provides for them and for their patients. The Association's role is to provide sufficient information which will permit members to make that decision which is best for them. The plan can be helpful to some physicians and of little or no help to others. To that end, an informational letter was sent to all members. Contact Mr. Herb Gillen or Mr. Bill Fry should you wish another copy of that bulletin.

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250 Rx only.

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SECOND OPINION

Medical and health responsibilities of the schools

By Frank Weinstock, M.D.

Although a school community has many of the same characteristics and problems as a larger, general community, its medical problems are unique. Youngsters have their own special diseases and problems, but the ability of physicians to treat those illnesses often are limited by their patient's minor status. In most cases, parental permission must be secured before treatment can be prescribed.

It is essential, therefore, that school boards, school personnel, and physicians recognize not only actual but potential medical problems which exist in these institutions and explore ways to correct them. Inappropriate handling of medical emergencies; a teacher giving wrong medications to a child (perhaps resulting in an allergic reaction); missing children on a screening exam; or inadequate training and care in sports, may have disastrous consequences for the pupil and the board.

One of the first steps a school board might take, for example, would be to establish a standing committee, comprised of voluntary administrative, medical, nursing and dental

consultants, who would evaluate the existing policies, deficiencies and needs of the school system, then devise an appropriate plan of action.

Much of their evaluation could be based on the American Medical Association's "Physician's Guide to the School Health Curriculum Process," which offers a comprehensive list of

"Inappropriate handling of medical emergencies . . . may have disastrous consequences for the pupil and the board."

activities to be followed in the areas of school health services and instruction, as well as steps to take toward a more healthful school environment. Physicians, specifically, can participate in the instruction process by evaluating textbooks and providing

input for additional health topics.

Once the evaluation process and follow-up plans have been completed, however, other areas of concern should be discussed.

Since emergencies, for example, are not scheduled, it is imperative that the school prepare a plan of action in case emergencies arise, then continuously update that plan.

Ideally, all staff personnel (and older students) should be trained in CPR (cardiopulmonary resuscitation) and should know the routine for emergencies. Information concerning personal physician, how to reach a parent (with one or two backups if the parent or guardian is unavailable) and hospital of choice, should be on record and **immediately** available. The number of local paramedics should be prominently displayed and known to all. In less urgent situations, the school should have a list of several physicians who would be willing to provide advice on the phone if there is a question on procedure. At athletic events, this information should be on the field and coins should be available

(continued on page 449)

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Second Opinion (continued)

for a pay phone. Ambulances should not be used for nonemergency situations if a private car is available, since once the ambulance leaves, a potentially critical situation is created for a spectator in the stands who might have a heart attack or other serious problem.

If a school is fortunate, an athletic trainer should be hired to assist in training and handling injuries. The physician should meet with the trainer and the coaches periodically to review routines for training and management of problems and injuries.

In the classroom, the management of communicable diseases should be updated. It is not unusual for students to be refused admission to school, even after the contagious period has elapsed and in spite of permission being granted by the private physician.

Preventive care is essential. Laboratories should be inspected by knowledgeable physicians and industrial leaders to establish safety standards for machines. Safety glass rules should be routine and inspection should be carried out to ensure that glasses meet industrial standards. A routine for the management of chemicals or foreign bodies in the eye should be known to all, and wash stations established in case accidents occur.

Dangerous foods, such as peanuts for the younger student, should not be allowed. The policy concerning junk foods in school should be clear.

There also should be a clear-cut policy concerning the teacher dispensing medications. Since most medications may cause serious side effects and allergic reactions, including death, a routine should be present. If

“Preventive care is essential. Laboratories should be inspected . . . dangerous foods for the younger student should not be allowed . . .”

the teacher gives a medication, the name and side effect should be known to all.

Teachers and students should know what to do if there is a possibility of a student having an epileptic seizure.

Vision, hearing and other health screening require physician input and guidance. The frequency and type of screening should be established. Standards of referral should be clear-

cut. It does little good to carry out screening if follow-up and referral methods are not adequate. A general concept is that children with vision in only one eye, hearing in only one ear, or with only one kidney, should not play contact sports such as football. If these children are discovered during routine screening or physicals, this information should be made available to coaches and flagged on the record for future protection of the student.

In summary, a comprehensive school health program should be established for school health services, school health instruction and for a healthy school environment. Local physicians should be involved to assist in the planning, administration and evaluation of the program. Among the physicians should be a pediatrician, ophthalmologist and orthopedist. A continuing program is essential to prevent injuries, protect children's health and treat problems efficiently, should they occur.

Frank Weinstock, M.D., is a member of the OSMA, and practices ophthalmology in Canton, Ohio.

Pharmacist acquitted of manslaughter in generic drug case

Ohio pharmacist Robert E. Cochran was acquitted of a charge of involuntary manslaughter, arising out of his substitution of a generic drug for a branded product.

He was, however, convicted of three counts of the sale of unapproved drugs and was sentenced to a 2-4-year suspended jail term. In addition, he must surrender his pharmacist license, sell his drugstore and pay all court costs from the 10-day trial.

In September, 1981, the 39-year-old druggist was charged with a 48-count indictment. One count concerned the substitution of the generic diuretic for the prescribed Lasix brand tablets. It was alleged that the substitution resulted in the death of Mrs. Cleo Schell, 62, who suffered congestive heart failure.

Lasix, an FDA-approved diuretic used in life-threatening situations, often on elderly heart patients, is the seventh most prescribed drug in the country.



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NEWS

a compilation of the latest developments, reports and products of interest to physicians.

**edited by
Gina DiBlasio Cummins**

Infant walkers latest health hazard

According to two pediatricians writing in a recent issue of the *American Journal of Diseases of Children*, not only is there no proven benefit from the use of infant walkers, those seats actually can be dangerous.

In a survey of parents of 150 children between the ages of five and fifteen months — all users of infant walkers — they found that 47 children suffered mishaps in their walkers. Most had bruises and abrasions but some had serious head injuries when the walkers either tipped over or fell down stairs. The authors admitted that their study lacked a control group who did not use walkers for comparison, however they concluded in their report that infant walkers are associated with a significant risk of injury, at least with their present design.

Infants, they said, certainly learn to walk without the practice they get in an infant walker; and they cited a study done elsewhere which found that infants who did not use walkers were walking slightly earlier than their siblings.

Caution encouraged in use of pediatric CAT Scans

Youngsters sedated to keep them still during a CAT scan have developed serious, and in some instances, life-threatening, drug-induced reactions.

In a collaborative study of Boston-area pediatric patients, researchers at Harvard Medical School and Boston University School of Medicine found that 13 of 106 children who were sedated prior to a CAT (Computed Axial Tomography) scan of the head developed adverse reactions. The risk appeared greatest when multiple drugs and high doses were used in combination, although the youngest infants reacted severely to normal doses of a single drug.

Allen A. Mitchell, M.D., director of the Pediatric Drug Surveillance Program run by the two Boston schools, was principal investigator for the study, which appears in a recent issue of the *Journal of the American Medical Association*.

The CAT scan itself involves only a low dose of radiation but, as the

Boston study shows, drugs used to keep the young patients motionless during the 15- to 30-minute procedure caused a wide range of problems from vomiting to life-threatening respiratory arrest. Children with more severe reactions required treatment with another drug to reverse the effects of the narcotics. There were no fatalities, however, and no apparent long-term consequences.

"We're not suggesting that CAT scans be avoided," says Dr. Mitchell. "The CAT scan is a noninvasive procedure that we've found invaluable in assessing problems like congenital malformations, brain tumors and injuries to the head. It is more accurate and less traumatic than older diagnostic techniques it replaces.

"What's important is choosing the right drugs and dosages for sedating the youngsters before a scan and then carefully watching them for signs of reaction both during the scan and afterward on the hospital ward," he concludes.

New cancer therapy on drawing board

Future cancer patients may be helped by a revolutionary new therapy now on the drawing board, but possibly a reality by the next decade.

The fledgling monoclonal antibody industry specifically examines the use of this latest biotechnology marvel to successfully attack cancer cells without harming any other tissues in the body.

The key to the whole process is the use of singularly specific, mass-produced antibodies. Development of a hybridoma — the fusion of a lymphocyte activated to a specific antigen and a myeloma cell — to a cell surface protein of a tumor will permit the production of monoclonal antibodies directed to that cell type and only that cell type. The mass-produced antibodies then can be used to intensify the body's own immunologic reaction to the

malignancy.

With the precision offered by monoclonal antibodies, identification of a tumor is only the first step in the road to successfully treating cancer. By "tagging" the antibodies with a powerful chemotherapeutic drug or radioisotope, large concentrations of the therapeutically important materials can be carried directly to the surface of the cancer cells. "A close parallel can be made between this strategy and a guided missile which can be directed to a very, very specific site," says Edward O. Lanphier II, Director of Biotechnology Research at International Resource Development, Inc., Norwalk, Connecticut. Industry observers have labeled this phenomenon the "magic bullet" theory and it is expected to be a reality for cancer patients by the early 1990s.



"Tonight's special" could be dangerous

Forget the black tie and tails. . . the short or long cocktail dress. The next time you dine out, perhaps the best thing to slip into is a flame-retardant asbestos suit.

In a recent issue of the *Journal of the American Medical Association*, Bruce M. Auchauer, M.D., and his colleagues at the University of California Medical Center in Irvine, reported on eight patients treated at the University's Burn Center for burns sustained from flaming desserts, entrees and drinks.

Four of the eight were restaurant patrons, two of whom were burned by a spilled, flaming cocktail, and two by cherries jubilee.

Cherries jubilee was the source of another incident, as inexperienced waiters tried to handle the menu's newest item, only to watch helplessly as flames shot out of the bottle they were using to ignite the dessert and burn the legs of a passing waitress. In another incident, a waiter tried to impress his employer with a flamboyant flame, as he was carrying an entree of beef brochette through the restaurant. He suffered burns over five percent of his body.

Local fire departments have begun to require special precautions of those restaurants serving flaming dishes — but the diner, as well as the restaurant employee, must be aware of the dangers involved in such a selection. At the very least, they could slip into something a little more appropriate, like that flameproof suit.

BOOK SHELF

Social Regulation: Strategies for Reform. Edited by Eugene Bardach and Robert A. Kagan. Institute for Contemporary Studies.

The book's coeditors, both political scientists, argue that many of the cumbersome and costly regulations imposed by the federal government on industry in recent years could be effectively replaced by private sector alternatives. This is particularly true, they write, of regulations governing pharmaceuticals and medical devices.

They cite the example of "orphan drugs" — drugs of potentially great value, but limited marketability since they go to a relatively small market. Faced with high, front-end drug approval costs, manufacturers are reluctant to become involved in the production of such drugs."

The authors provide examples of programs that are more flexible, responsible and economical than present command-and-control regulations.

The book may be ordered from Institute for Contemporary Studies,

Social reform . . . senility explored . . .

260 California St., No. 811, San Francisco, Ca. 94111.

The 36-Hour Day. By Nancy L. Mace and Peter V. Robins, M.D. The Johns Hopkins University Press. \$14.95 hardcover, \$6.95 paperback.

The long subtitle, "A Family Guide to Caring for Persons with Alzheimer's Disease, Related Dementing Illnesses, and Memory Loss in Later Life," explains the book's purpose. Developed at Johns Hopkins School of Medicine, the book offers guidance on the many problems that arise in illnesses once called "senility": diagnosis, medical care, home care, nursing homes, legal problems, financial matters, understanding patient behavior and mood changes. Both practical and supportive, the guide is a handbook on coping with an extraordinarily difficult condition. It is endorsed by the Alzheimer's Disease and Related Disorders Association.

MISCELLANEA

The Medical College of Ohio is seeking historical information relating to the establishment of MCO and to medical education, particularly in Northwest Ohio.

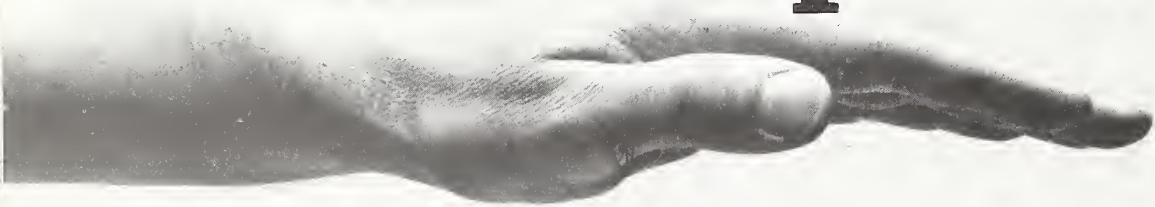
"MCO was established in December, 1964, by the Ohio Legislature, accepted its first students in 1969, and graduated its first class of medical doctors in 1972," notes Richard D. Ruppert, M.D., the third president in the school's history.

"This June we will graduate our 11th class, including for the first time, nurses who have earned master's degrees, and we are looking forward to observing the 20th anniversary of our founding in 1984," Dr. Ruppert adds. "There are a couple of histories of MCO in the works and there exist some histories of medical education in this area. We want to see what else is available related to the establishment of this school."

Anyone wishing to contribute information or memorabilia is urged to contact William McMillen, M.D., 419-381-4260.

• Oraflex (benoxaprofen), a new once-a-day medication for the treatment of arthritis, has been approved for marketing in the U.S. by the Food and Drug Administration. The product is indicated for the treatment of the two most common types of the disease, osteoarthritis and rheumatoid arthritis. It has a low rate of the serious gastrointestinal side effects, sometimes associated with antiarthritis medication. A sun-related side effect involving the skin or nails, has been seen in some patients treated with Oraflex, but it is generally mild, can be avoided, and seldom interferes with treatment. Recommended dose is one 600 mg tablet once a day. Developed by Eli Lilly and Company.

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CHARLES BRANDEN, M.D. was elected president of the medical staff of Marymount Hospital, Bedford. Also elected were: **JOHN MARGRETT, M.D.**, president-elect of the medical staff and chairman of the medical council; **GARY KLEINMAN, M.D.**, secretary of the medical staff; and **WILLIAM BRUCK, M.D.**, treasurer of the medical staff.

DAVID J. DORTIN, JR., M.D., Cincinnati, was elected president of the Ohio Thoracic Society. Dr. Dortin is director of the department of pulmonary medicine at Jewish Hospital.

WILLIAM C. DOWNING, M.D., Painesville, was appointed chairman of the board for the "Learning About Business" program at Lake Erie College. Dr. Downing is a surgeon and is director for Bank One and Mercury Plastics, Inc.

ROBERT L. GIROUARD, M.D., Covington, was appointed by the Miami County Medical Society to the Dettmer Hospital board of trustees. Dr. Girouard is a general practitioner in Covington, Ky.

BERNARD KUHR, M.D., Columbus, was elected president-elect of the Ohio Psychiatric Association.

The following were elected officers of the medical staff of Kettering Medical Center: **RICHARD B. REILING, M.D.**, Kettering, general and vascular surgeon, chief of staff; **JAMES D. RUFFNER, M.D.**,



Frank M. Barry, M.D., Distinguished Service Award winner (left) is pictured with Richard J. Nowak, M.D. and Robert M. Zollinger, Jr., M.D. (right) at the Cleveland Academy of Medicine's recent annual meeting. (Photo courtesy of Stephen Lee.)

Cleveland Academy members honored.

The Academy of Medicine of Cleveland was pleased to honor several members at their most recent annual meeting, held this year at Stouffer's on the Square.

Elden C. Weckesser, M.D., was designated a "Distinguished Member" of the Academy, one of the highest honors the Academy can bestow. Dr. Weckesser, a general surgeon and hand surgeon, served on the Academy's Board of Directors for six years, and as the Academy's president in 1967-1968. He has also presided over the Western Reserve University Medical Alumni Association and served a two-week stint as a volunteer physician at Ft. Defiance Hospital on the Navajo Indian Reservation in Arizona.

Frank M. Barry, M.D., **John H. Sanders, M.D.**, and **Earl E. Smith, M.D.**, were honored with Distinguished Service Awards. **Frederick R. Schnell, M.D.**, an internist, was named "Clinician of the Year."

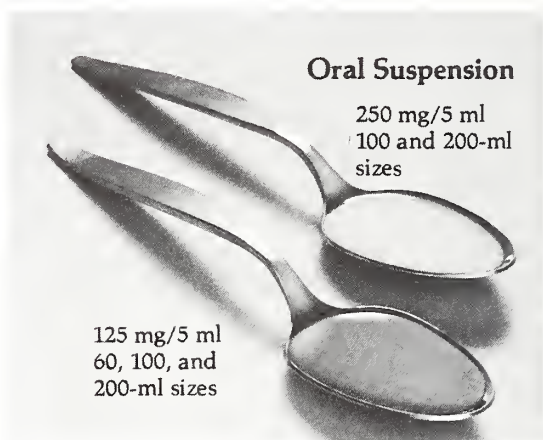
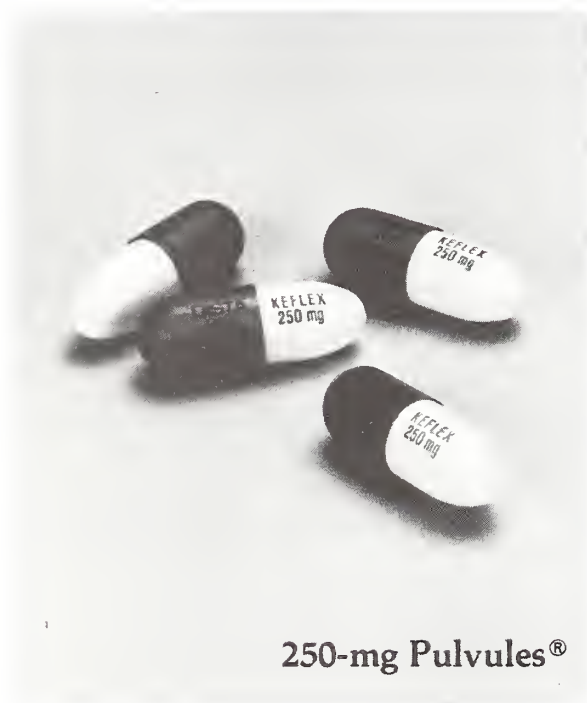
In other business **Ray Wallace Gifford, Jr., M.D.** was installed as 1982-1983 President, replacing **Robert M. Zollinger, Jr., M.D.** In his final address to the Academy, Dr. Zollinger pointed out that the culmination of two major struggles was achieved this year by the Academy: "(1) an agreement on the concept of voluntary, private utilization review, and (2) a voluntary restructuring of the patterns of providing emergency care."

Miamisburg, family medicine, chief of staff-elect; **DAVID G. SMALL, M.D.**, Springboro, general surgeon, vice chief of staff-elect; and **RAYMOND G. RUSSELL, M.D.**, Kettering, internal and pulmonary medicine, secretary.

THOMAS R. WERNER, M.D., Cincinnati, was elected president of

the Ohio Psychiatric Association. Dr. Werner is on the board of trustees of the Cincinnati Psychiatric Society and is assistant clinical professor of psychiatry and assistant professor of environmental health at the University of Cincinnati College of Medicine.

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When medicine meets business . . .

By Leonard Rome, M.D.

The election of Ronald Reagan and the subsequent announcement of the New Federalism signaled a shift in the relationship between the public and private sector in terms of health care delivery.

Through our local, state, and national medical and specialty societies we now have an opportunity to address important issues which affect patient care. We also are in a position to determine the destiny of our profession.

It seems clear that while Washington is less interested in controlling us, we are not free from control. Employers, insurance carriers, labor unions, and private individuals are aware of the need for action. We can act alone or we can act together, but we must act.

For several years, the American Medical Association (AMA) has been working to promote the formation of medicine/business coalitions on local, state and national levels. In mid-1978, the AMA began its Corporation Visitation Program which brought together key AMA spokespeople and the leaders of major business organizations to discuss the rising cost of medical care, the corporations' specific problems in this area, and other related subjects. By the end of 1980, the AMA had met with over 500 corporate executives from 100 of the FORTUNE 500.

In addition to the AMA, several other organizations also have been working to develop coalitions. As a result, approximately 90 coalitions

Health care costs are of great concern not only to organized medicine, but also to American industry.

Health care costs are of great concern not only to organized medicine but also to American industry. Meetings between local major industries and state and county medical societies for the purpose of finding common ground and joint solutions can benefit physicians as well as the public.

have been formed nationwide. One half of these are broadly representative and include medical societies, hospital association, employers, insurance carriers, labor representatives and other interested parties. The remaining coalitions are more limited, and typically are formed by business groups which do not include

physicians or hospital administrators.

Thirteen of the local coalitions have gone beyond the initial discussion steps to establish a data base on local utilization of health care services and a utilization review program. Other discussion items include health promotion/wellness programs, employee education programs, community health planning involvement, participation by coalition members on local hospital governing boards and hospital trustees education programs.

The AMA coalition which includes the American Hospital Association, Blue Cross/Blue Shield, Business Roundtable, and AFL-CIO suggests the following projects with potential for cost effective delivery of health care:

1. Encouraging efforts to place less emphasis on expensive inpatient technology and more emphasis on alternative forms of care, including ambulatory and home care.

Among the activities that may accomplish this objective are:

- Redesigning insurance benefits to emphasize preventive, primary, and home care.
- Case management and utilization review.
- Encouraging efforts to modify the

use of hospital beds, to make the most appropriate use of community health resources.

2. Increasing access to care:

- Efforts to finance and provide health care for the unemployed and others who do not have access to care.
- Efforts to mitigate the impact of federal, state and local budget changes on health care in the community.

3. Increasing opportunities to develop the most cost effective and equitable forms of provider payments.

4. Developing more effective programs of health promotion and disease prevention at the work place.

Joint medical/business coalitions offer potential benefits to all involved parties. A partial list is offered in an AMA publication entitled **The Formation of Medical/Business Coalitions**. The potential advantages for business include an opportunity to:

- Communicate a variety of problems to organized medicine
- Find joint solutions to problems.
- Provide a wide range of information to employees for their improved health.
- Present an improved image to the public.
- Expand corporate staff knowledge of health care problems and solutions.

- Provide guidance to other industries.

- Advance, for the good of the company and its employees, the financial strength and stability of the company.

Advantages for medicine include an opportunity to:

- Maintain a leadership role, specifically as it relates to health care issues.
- Improve medicine's image with government, labor, the general public and the business and industrial community.
- Provide the best expertise to decision-making regarding the cost of health care.
- Build a strong alliance with philosophical friends.
- Provide yet another service for the general public.

While the primary focus of local coalitions varies according to community need, they should first agree on a list of issues which are germane to that area and second, develop a strategy to address those problems.

It is impossible to know for certain if the coalition effort will succeed. What we do know for certain is that:

1. The philosophy in Washington,

What the AMA is doing

In a period when the economy in general is creating growing national concerns, a relatively new group, the health care coalition, is coming to the fore as a promising voluntary organization to deal with the problems of rising health care costs.

At the national level, the AMA has joined with the American Hospital Association, the Blue Cross and Blue Shield Associations, the Business Roundtable, the Health Insurance Association of America, and the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO) to endorse the concept of voluntary coalitions. Members of the national groups have agreed also to encourage members and local affiliates

to participate together in such coalitions.

For the AMA, supporting the development of health care coalitions is a natural extension of its activities over the past three years in developing contacts at the national level with business and industry groups. The AMA also has encouraged state and local medical groups to establish dialogues with businesses and industries in their areas to discuss common concerns about health care delivery.

The AMA believes that these coalitions have the promise of being the most effective mechanisms for containing health care costs. Even though a local coalition of providers,

insurers, business and labor may not necessarily develop new cost-effectiveness ideas, it can create a better base of support for implementation of effective programs.

However, the AMA believes it is imperative that health care coalitions have physician participation so that primary emphasis is given to quality and availability of medical care and access to it, as well as to cost effectiveness and cost containment. Organized medicine must participate. Now is the time for medical societies to enlarge their leadership role and show the way. The larger our membership, the greater our influence and strength as medicine's representatives.

D.C. is to turn more and more responsibility back to states and local communities.

2. The New Federalism signals the demise of PSROs and HSAs as we have known them.

3. Business leaders are becoming increasingly concerned and involved in decisions about the cost and delivery of health care.

4. Failure to develop workable solutions to problems involved in the cost and delivery of health care on a local level will result in imposed solutions.

The private sector is in a position to demonstrate its ability to solve local problems. It is true that the members of coalitions have in the past been adversaries who blame one another for the multitude of problems in our health care delivery system. It is also true that coalition members will have different priorities. In spite of these differences, coalitions are an opportunity for people with varying points of view to exchange ideas and learn from one another. All involved parties recognize that further government intrusion will result in lower quality medical care. Coalitions appear to be our best way to protect the health care of the people we serve, our patients.

IN FORMING COALITIONS ARE WE RECYCLING PEER STANDARD REVIEW ORGANIZATIONS AND HEALTH SYSTEMS AGENCIES?

Both programs were mandated from Washington, D.C. and imposed on physicians. HSAs in particular were heavily regulated and states and communities were required to conform to federally imposed standards.

Coalitions are voluntary. A coalition may set its own agenda based on needs. Coalitions may be informational or action oriented. The members, not government, decide what to do.

IF WE DO BECOME INVOLVED HOW CAUTIOUS MUST WE BE?

Involvement in coalitions involves a delicate balance between good faith cooperation and caution. Members of coalitions will have different priorities. Being cautious means understanding our priorities and goals and being willing to discuss any item, and then consider proposals in terms of how

they affect our priorities and goals. We must distinguish between caution and defensiveness.

WHY ARE COALITIONS FORMING AT THIS TIME?

Business and insurance carriers are concerned with the cost and delivery of health care. Some corporations are realizing that they have a social responsibility as well as a profit motive. Companies pay taxes to communities to support schools. They employ parents who spend dollars in a community and also pay taxes. The long-term success of business in a community depends on stability of the community; therefore, many businesses recognize involvement as

... Coalitions are an opportunity for people with varying points of view to exchange ideas and learn from one another.

an obligation. If a community deteriorates, people who might work for a company won't locate there. The result is an inadequate labor supply. If young parents move out, leaving an older population, school levies will fail and the quality of education will suffer. The result again will be the unwillingness of people to locate in that community.

A community must be attractive to the kind of people a company wants to employ. We can view this in terms of schools, theaters, restaurants, museums, or health care services, to name just a few considerations.

If health care costs in a community are too high or if there is a perceived overbedding problem, that adds to the cost of a company's health benefit package which affects that company's cost of doing business and their competitive position in the marketplace.

Finally, as the federal government withdraws from direct control of health care, business sees a void which must be filled. While they

philosophically oppose government regulation, they fear expansion of health care facilities in an unchecked environment.

HOW ACCOUNTABLE ARE THE BOARDS OF TRUSTEES OF COALITIONS?

They are as accountable as the community and the members make them. Certainly, physicians should be involved directly as participants in, or monitors of, coalitions. The broader the scope of resources available to coalitions, the better able they will be to make informed recommendations or decisions. The use of print and electronic media is an important way to assure not only accountability, but also responsiveness of coalitions.

WHAT IS THE RESPONSIBILITY OR LIABILITY OF A COALITION?

Board members must act in a reasonable and prudent manner. Any person may argue that a board has not met the reasonable and prudent standard.

It seems wise for a coalition to incorporate as a 501(c)(3) charitable or educational foundation as defined by IRS. Also, an indemnification feature should be built in to protect board members. A board of trustees must be aware of antitrust regulations and avoid actions which may constitute restraint of trade or boycott. Sound legal advice is required in these areas.

WHAT WILL A COALITION DO FOR THE INDIVIDUAL PHYSICIAN?

A coalition with physician involvement on a local level gives the individual physician a pathway to express his opinions or ideas to an organization. The closer to home a policy-making body is, the more influence one can have on the direction the organization takes. On a local level, a physician is much more likely to get a response to his ideas or concerns than on a national level. State legislators view six to ten letters on a given issue as a significant response. Locally, two or three physicians with an idea could have an impact. The key is to become involved.

Leonard Rome, M.D., is a member of the OSMA and practices pediatrics in Shaker Heights, Ohio.



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As an Ohio physician, you were ineligible for group malpractice insurance, missing out on the lower-priced premiums that make group plans so attractive. But joint action by the OSMA and PICO has changed that . . .

The New Group Liability Plan

By Carol Wright Mullinax

You may sometimes feel you are drowning in a sea of organizations, associations and groups, but until now one group has remained beyond your reach. As an Ohio physician, you were ineligible for group malpractice insurance and, as a result, missed out on the lower-priced premiums that make group policies so attractive. Joint action by the OSMA and the Physicians Insurance Company of Ohio (PICO) has changed that.

Working closely together, the OSMA and PICO created the Group Professional Liability Insurance Plan that is now available to OSMA members. C. Douglass Ford, M.D., Toledo, OSMA's newly installed president, says it is a plan OSMA members can be proud of: "We have broken new ground by creating this type of professional liability insurance

and we are pleased to be able to offer it to our members."

In the past it was believed that professional liability insurance, unlike some forms of insurance, could not be written as a group policy. However, PICO, as part of its ongoing search for ways to upgrade insurance coverage, determined that while it was true that no group policy of this type had ever been written in Ohio, state statutes did not specifically prohibit it.

Armed with this knowledge, the OSMA and PICO devised the new group plan. This new policy is being underwritten by PICO and issued to the OSMA as one entity. The OSMA, in turn, is to issue certificates of coverage to all participating members of the group — OSMA members.

Dr. Ford stresses that the new group plan offers **exactly** the same coverage

as PICO's individual professional liability policies. The traditional risk classifications previously set by PICO remain in effect. Starting July 1st, physicians presently holding PICO Professional Liability policies, will be automatically switched to the new group policy on their policy's renewal date. Physicians wishing to switch from other insurance company plans will need to contact the OSMA or PICO before their present policy expires. It is important for members to note that the new group plan applies to primary coverage only. The limit choices are \$100,000/\$300,000 and \$200,000/\$600,000. PICO will continue to write excess professional liability insurance and other types of insurance directly through its network of independent agents.

OSMA members participating in this

new group plan will reap one benefit immediately — a 20 percent decrease across the board in the cost for primary coverage. But there are also some long-term benefits that Dr. Ford feels members should not overlook. For example, a profit sharing agreement which will allow members of the group to profit from the plan's success. But there is another, more important, benefit that Dr. Ford feels is vital: peace of mind. He points out that the causes of the mid-seventies' "malpractice crisis" have not disappeared and many experts are predicting yet another crisis in a few years. Not only could many physicians find their premiums skyrocketing, but some insurance companies could face financial failure due to the increased economic pressures brought on by the crisis. "Since PICO and OSMA will be keeping a sharp eye on the premiums charged, physicians can be certain they are paying the lowest and most

"Since PICO and OSMA will be keeping a sharp eye on the premiums charged, physicians can be certain they are paying the lowest and most appropriate rate possible. . ."

appropriate rate possible for their professional liability insurance. And they will be protected as much as possible from sharp increases in rates or sudden surcharges that could stem from a malpractice crisis," Dr. Ford says, adding that group policyholders can also be safe in the knowledge that PICO and the OSMA are stable enough to withstand any forthcoming insurance crisis.

OSMA members will be receiving more information on the new group policy both from the association and from PICO in the near future. Dr. Ford urges physicians to take a few minutes to study the new group policy. "I think this new plan is one of the more important member benefits offered by the OSMA," Dr. Ford says, "and I hope all of our members will be pleased with it."

Carol Wright Mullinax is the Associate Director, Department of Communications.

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INDEX TO ACTIONS ON RESOLUTIONS

Editor's Note: Report of Resolutions Committee No. 1 begins on page 483; Resolutions Committee No. 2 on page 489; Resolutions Committee No. 3 on page 495. This index is for reference purposes and is not part of the Official Proceedings of the 1982 House of Delegates.

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*Hannemann, R. E., Erb, R. J., Stoltman, W. P., Bronson, E. C., Williams, E. J., Long, R. A., Hull, J. H. and Starbuck, R. R.: Digital Plethysmography For Assessing Erythrityl Tetranitrate Bioavailability. Clin Pharmacol and Ther 29:35-39, 1981.

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ual exhibits marked sensitivity to the hypotensive effects of nitrates and severe responses (nausea, vomiting, weakness, restlessness, pallor, perspiration and collapse) can occur even with the usual therapeutic dose. Alcohol may enhance this effect. Drug rash and/or exfoliative dermatitis may occasionally occur.

DOSAGE AND ADMINISTRATION

Oral / Sublingual Tablets: Cardilate (Erythrityl Tetranitrate) may be administered either sublingually or orally. Therapy may be initiated with 10 mg, prior to each anticipated physical or emotional stress and at bedtime for patients subject to nocturnal attacks. The dose may be increased or decreased as needed.

HOW SUPPLIED:

CARDILATE (Erythrityl Tetranitrate) TABLETS (Scored)
for ORAL or SUBLINGUAL USE 5 mg: Bottle of 100;
10 mg: Bottles of 100 and 1000; 15 mg: Bottle of 100

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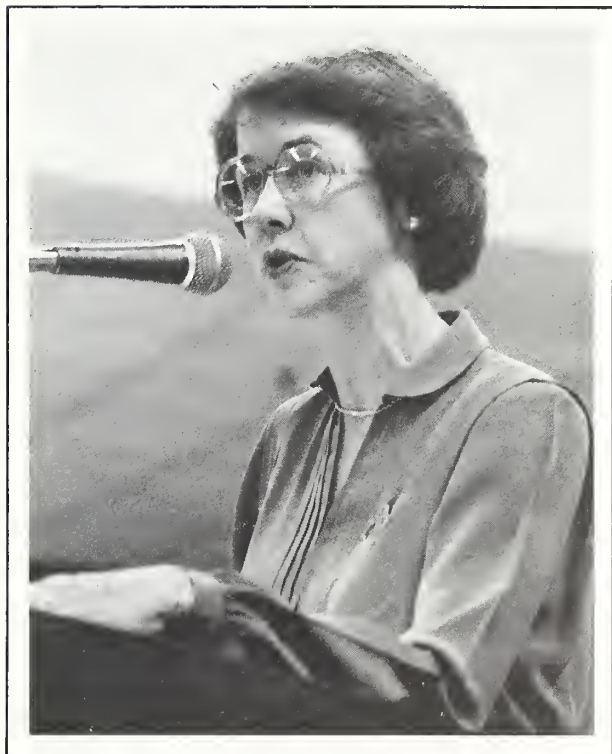


Wellcome

Highlights of '82

This was the first year for the abbreviated business section of the OSMA Annual Meeting. The House of Delegates opened on . . .

Friday night



*Shirley Davies, Troy, reporting as President of the Auxiliary . . .
"We are in this together — we must attain synergism."*



William M. Wells, M.D., Newark, Chairman of the Board of the Physicians Insurance Company of Ohio (PICO), updates the assembled House on the activities of PICO, including the development of a new group liability plan.

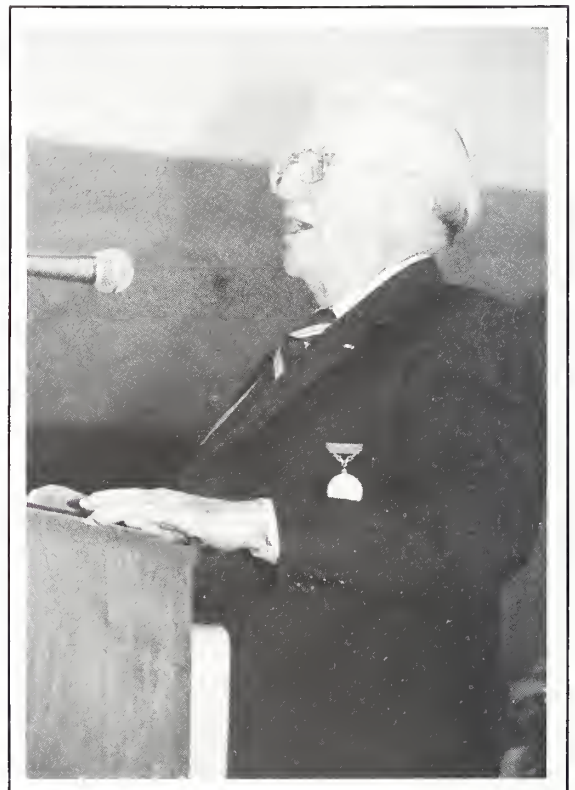
Friday night (continued)



*Richard L. Meiling, M.D., Columbus, — honored for his years of service as Consulting Medical Editor to the **Ohio State Medical Journal** — receives a plaque and handshake from President Stewart Dunsker, M.D., Cincinnati, as Mrs. Meiling looks on.*

THE **Ohio** STATE **Medical** **Journal**

... honors its Consulting Medical Editor



Dr. Meiling addresses the House.

Plaques were presented by C. Douglass Ford, M.D., Toledo, to those chairmen of state committees, and members of standing committees who were retiring from office. They included . . .



Alford C. Diller, M.D., Van Wert (left), accepts his plaque from Dr. Ford. Dr. Diller retires as Advisor to the Medical Assistants, and as a member of the Auditing and Appropriations Committee.



Dr. Ford (far left) stands with Anthony Ruppberg, M.D., Columbus, retiring as Chairman of the Maternal and Neonatal Health Committee — a position he held for 28 years.

Retiring Chairmen

S. Baird Pfahl, M.D.

Sandusky
Auditing and Appropriations
Committee
Auxiliary Advisory Committee

Alford C. Diller, M.D.

Van Wert
Advisor to Medical Assistants
Medical Services Review Committee

Harry H. Fox, M.D.

Cincinnati
Art and Culture Committee

Thomas R. Leech, M.D.

Lima
Committee on Communications

Anthony Ruppberg, Jr., M.D.

Columbus
Maternal and Neonatal Health
Committee

Max. D. Graves

Springfield
Committee on Mental Health

(continued on page 466)

Friday night (continued)

Retiring chairmen (continued)

Paul L. Weygandt, M.D.
Akron

Standards for School Bus Drivers
Committee on Traffic Safety

Brady F. Randolph, Jr., M.D.
Hamilton

Sports Medicine Advisory

A. Burton Payne, M.D.
Ironton

Committee on State Legislation



The Montgomery County Medical Society's Glee Club, directed by W. J. Lewis, M.D., performed after the opening session.

... and Dr. Dunsker delivered his President's address.

The year was a busy and fruitful one for the Cincinnati neurosurgeon who assumed office during the last Annual Meeting in Cleveland, Ohio.

He mentioned that, during his term in office, he was able to watch membership in the OSMA continue to develop and grow. He has seen the organization follow through on additional sources of revenue, such as income from the telecourse system, and from the purchase of property adjacent to the OSMA headquarters in Columbus. He was excited about launching OSMA's newest company — PACO (Physicians Administrative Company) — which will utilize, among other services, direct entry billing for Medicare claims. He cited OSMA's patient publication, *Synergy*, which he said has helped the citizens of the Ohio community learn to take care of themselves, and mentioned that work has begun on establishing an editorial board for the *Journal* which will aim to make that publication even

more responsive to its readers' needs. He also lauded the Auxiliary's expanding role in the Association through work on its Council and committees.

There's still a lot of work to do, he emphasized. Liability concerns will continue to grow, but work initiated on a group liability program through PICO may help to reduce future liability rates for members. He also supported the health care coalitions, recently formed by the OSMA, which will attempt to reduce the problem of spiraling health care costs. Physician population will continue to grow, so the OSMA will continue its study into marketing and competition.

"But," he concluded, "we must work together to decide how health care will be delivered in the future — to shape our own destinies. Status quo is no longer an option."



Stewart B. Dunsker, M.D.

Saturday

The Art and Culture Committee played an active role this year with its display of Pre-Columbian artifacts.

Volcanoes, earth, fire, water and stone.

They are not the usual ingredients for an OSMA Annual Meeting but this year an exhibit of Pre-Columbian art created an ancient culture's ambience for harried attendees.

The exhibit, sponsored by the OSMA's Art and Culture Committee, featured artifacts from several distinct Pre-Columbian cultures: Chorotega, Brunka, Huetar, Maya, Chancay and Western Mexican village cultures. The artifacts were loaned to the committee from the private collections of three

OSMA members. Jack Singer, M.D., Cincinnati, displayed approximately 30 pieces of Pre-Columbian pottery that he collected during his travels in Central and South America. Otilia and Adelaida Fernandez, medical students at the University of Cincinnati College of Medicine, exhibited more than 50 artifacts from their private collection, owned in conjunction with their brother, Emilio T. Fernandez, a student of architecture at the University of Cincinnati.

The exhibit also featured the entries of the 1982 Journal Photo Contest.



Sick Man. Circa 800-1000AD. Chorotega. Sick man in process of drinking his medicine, probably a concoction prepared by the local "witch doctor."



Pregnant Woman (above) and Pre-Columbian Midwife (below). Circa 1000-1200 AD. Chorotega. The pregnant woman is in the typical Pre-Columbian kneeling position for labor and childbirth. Note that when the figure is placed on her back, it duplicates the modern position for delivery. The other figure is that of a Pre-Columbian Midwife, with a vessel, waiting to aid the mother. The expressions of the pregnant woman show her experiencing labor pains and contractions, while the midwife has a smile of contentment for her role in the birth of a new life.

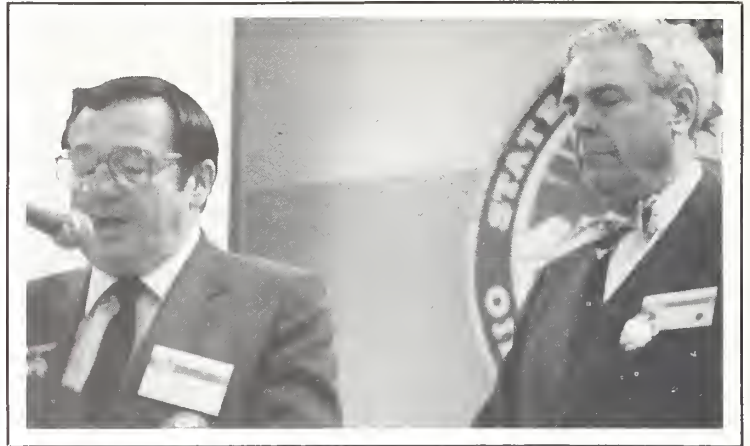
The OMPAC Luncheon, with speaker Mark Shields.



Mark Shields, Washington Post writer and columnist.

Sunday night

C. Douglass Ford, M.D., is installed as OSMA's new President.



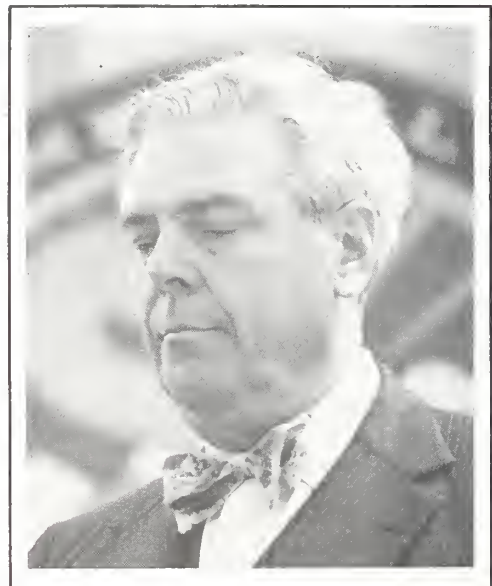
Immediate Past President Robert G. Thomas, M.D., Elyria, installs Dr. Ford.



Dr. Ford presents his wife, Betsy, and their six children to the House.



Dr. Ford's first presidential act was to present the past president's plaque and pin to Dr. Dunsker and his wife Ellen.



C. Douglass Ford, M.D. . . . OSMA's new President

Sunday night (continued)

The rest of the evening was given over to business . . . as the House listened to reports of Resolution Committees, and, of course, the ensuing debates.



S. Baird Pfahl, Jr., M.D., Sandusky, OSMA's new President-Elect.



Paul Metzger, M.D., Columbus, reads the report of his Committee, as Dr. Dunsker, behind him, follows on his copy.

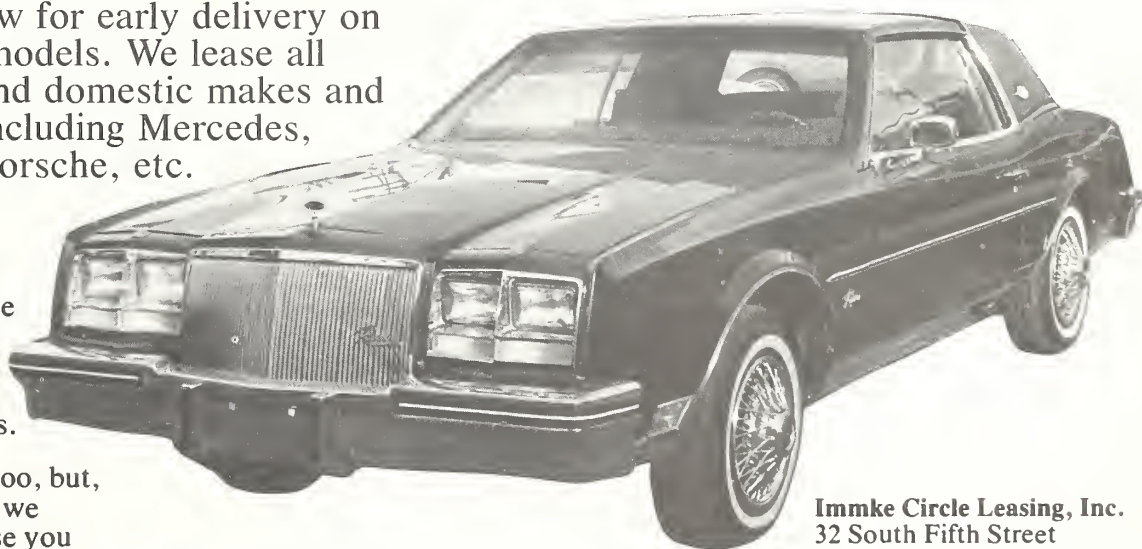
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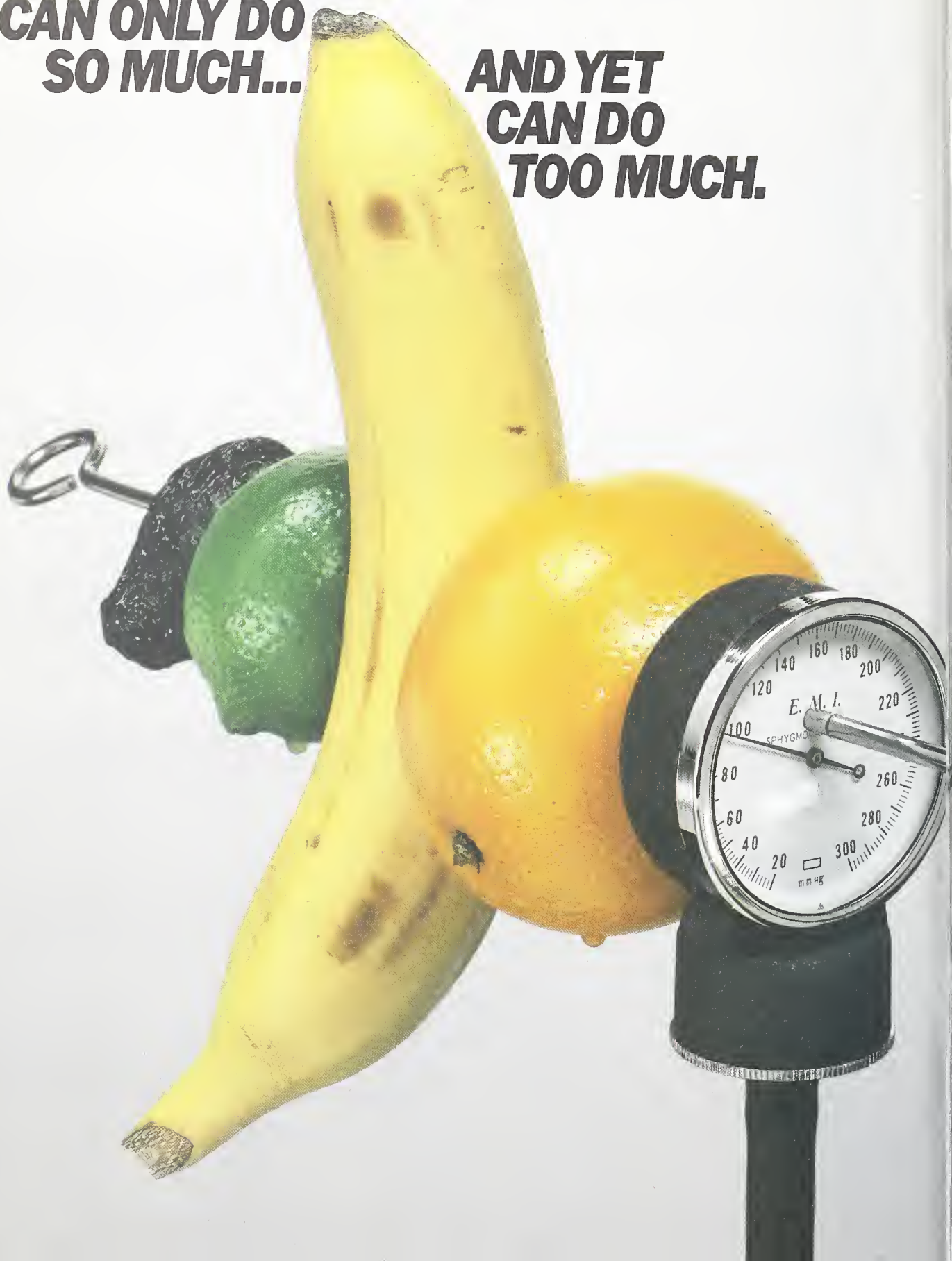


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**AND YET
CAN DO
TOO MUCH.**



INCREASE CONTROL WITHOUT INCREASING POTASSIUM PROBLEMS.

A dependable means to long-term blood pressure control.

Many times, a diuretic alone can't keep hypertension in check. *INDERIDE*, however, can pick up where thiazide therapy leaves off.

The combination of propranolol HCl, the world's most trusted beta blocker, and hydrochlorothiazide, the standard among diuretics, enables *INDERIDE* to exert an additive antihypertensive effect.^{1,2} In fact, a propranolol/hydrochlorothiazide regimen maintained blood pressure below 90 mm Hg in 81.8% to 86.4% of patients followed for 6 to 18 months of therapy.¹

Low thiazide dosage means reduced risk of hypokalemia.

When thiazides are prescribed in doses greater than 50 mg/day, the potential for hypokalemia increases substantially. What's more, the greater the fall in serum K⁺, the greater the risk of hypokalemia-induced PVCs.^{3,4}

With *INDERIDE*, the additive hypotensive effect of propranolol HCl allows the effective dose of hydrochlorothiazide to be kept low (25 mg b.i.d.). And by lowering the daily dose of diuretic, *INDERIDE* also lowers the potential for diuretic-induced side effects. Potassium problems are less likely to occur—yet blood pressure can be controlled consistently.



INDERIDE[®]

Each tablet contains *INDERAL[®]* (propranolol HCl) 40 mg or 80 mg, and hydrochlorothiazide 25 mg | **B.I.D. 40/25
80/25**

When you know you need more than a thiazide.

Please see Brief Summary of Prescribing Information on following page.

BRIEF SUMMARY
(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERIDE®

BRAND OF
propranolol hydrochloride
(INDERAL®)
and hydrochlorothiazide

No. 474—Each IINDERIDE®-40/25 tablet contains: Propranolol hydrochloride (INDERAL®)	40 mg
Hydrochlorothiazide	25 mg
No. 476—Each IINDERIDE®-80/25 tablet contains: Propranolol hydrochloride (INDERAL®)	80 mg
Hydrochlorothiazide	25 mg

WARNING: This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

DESCRIPTION: IINDERIDE combines two antihypertensive agents. IINDERAL (propranolol hydrochloride), a beta-adrenergic blocking agent, and hydrochlorothiazide, a thiazide diuretic-antihypertensive.

INDICATION: IINDERIDE is indicated in the management of hypertension. (See boxed warning.)

CONTRAINDICATIONS: **Propranolol hydrochloride (INDERAL®):** Propranolol hydrochloride is contraindicated in: 1) bronchial asthma, 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol, 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS: **Propranolol hydrochloride (INDERAL®):** CARDIAC FAILURE. Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely: a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn, b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA: Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

USE IN PREGNANCY: **Propranolol hydrochloride (INDERAL®):** The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

Hydrochlorothiazide: Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers: Thiazides appear in breast milk. If the use of the drug is deemed essential, the patient should stop nursing.

PRECAUTIONS: **Propranolol hydrochloride (INDERAL®):** Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncope attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause are: dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements such as foods with a high potassium content.

Any chloride deficit is generally mild, and usually does not require specific treatment except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

ADVERSE REACTIONS: **Propranolol hydrochloride (INDERAL®):** Cardiovascular bradycardia, congestive heart failure, intensification of AV block, hypotension; paresthesia of hands; arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Miscellaneous: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

Hydrochlorothiazide: **Gastrointestinal:** anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

Central Nervous System: dizziness, vertigo, paresthesias, headache, xanthopsia.

Hematologic: leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular: orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: purpura, photosensitivity, rash, urticaria, necrotizing angitis (vasculitis, cutaneous vasculitis), fever, respiratory distress including pneumonitis, anaphylactic reactions.

Other: hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

DOSEAGE AND ADMINISTRATION: The dosage must be determined by individual titration (see boxed warning).

Hydrochlorothiazide is usually given at a dose of 50 to 100 mg per day. The initial dose of propranolol is 40 mg twice daily and it may be increased gradually until optimum blood pressure control is achieved. The usual effective dose is 160 to 480 mg per day.

One to two IINDERIDE tablets twice daily can be used to administer up to 320 mg of propranolol and 100 mg of hydrochlorothiazide. For doses of propranolol greater than 320 mg, the combination products are not appropriate because their use would lead to an excessive dose of the thiazide component.

When necessary, another antihypertensive agent may be added gradually beginning with 50 percent of the usual recommended starting dose to avoid an excessive fall in blood pressure.

OVERDOSAGE OR EXAGGERATED RESPONSE: The propranolol hydrochloride (INDERAL®) component may cause bradycardia, cardiac failure, hypotension, or bronchospasm.

The hydrochlorothiazide component can be expected to cause diuresis. Lethargy of varying degree may appear and may progress to coma within a few hours, with minimal depression of respiration and cardiovascular function, and in the absence of significant serum electrolyte changes or dehydration. The mechanism of central nervous system depression with thiazide overdosage is unknown. Gastrointestinal irritation and hypermotility can occur, temporary elevation of BUN has been reported, and serum electrolyte changes could occur, especially in patients with impairment of renal function.

TREATMENT: The following measures should be employed. **GENERAL:** If ingestion is, or may have been, recent, evacuate gastric contents taking care to prevent pulmonary aspiration. **BRADYCARDIA:**—Administer atropine (0.25 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously. **CARDIAC FAILURE:**—Digitalization and diuretics. **HYPOTENSION:**—Vasopressors, e.g., levaterenol or epinephrine. **BRONCHOSPASM:**—Administer isoproterenol and aminophylline. **STUPOR OR COMA:**—Administer supportive therapy as clinically warranted. **GASTROINTESTINAL EFFECTS:**—Though usually of short duration, these may require symptomatic treatment. **ABNORMALITIES IN BUN AND/OR SERUM ELECTROLYTES:** Monitor serum electrolyte levels and renal function; institute supportive measures as required individually to maintain hydration, electrolyte balance, respiration, and cardiovascular renal function.

HOW SUPPLIED: No. 474—Each IINDERIDE®-40/25 tablet contains 40 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 476—Each IINDERIDE®-80/25 tablet contains 80 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100.

References: 1. Veterans Administration Cooperative Study Group on Antihypertensive Agents. JAMA 237:2303 (May 23) 1977. 2. Bravo, E. L., Tarazi, R. C., and Dustan, H. P. N. Engl. J. Med. 292:66 (Jan 9) 1975. 3. Hollifield, J. W., and Slaton, P. E. Acta Med. Scand. [Suppl.] 647:67, 1981. 4. Holland, O. B., Nixon, J. V., and Kuhnert, L. Am. J. Med. 70:762 (Apr) 1981.

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C. Douglass Ford, M.D.

President of the Ohio State Medical Association

Building strength . . . on a bedrock of humor

By Karen S. Edwards

Humor is the grease that allows everything to move more smoothly.

It's the kind of philosophy that brings American humorists Mark Twain and Will Rogers to mind, but the warm, almost homespun homily belongs to the Ohio State Medical Association's (OSMA) newest President, C. Douglass Ford, M.D., the Toledo internist who assumed office at this year's Annual Meeting in Dayton, Ohio.

His goals, however, are perfectly serious.

"I want to increase the Association's effectiveness to its members," he says, adding that he plans to husband those changes that have been made already along those lines, programs such as the Physicians Insurance Company's (PICO) IRA plan; the ombudsman program; and, more recently, the group malpractice plan which he says, "should entice more Ohio physicians to join."

"I particularly want to see PACO (Physicians Administrative Corporation of Ohio) grow this year. PACO has been established to provide those personal services which physicians need."

By augmenting these services with new ones of his own (see Dr. Ford's President's Page for more on the group insurance plan Dr. Dunsker

initiated), Dr. Ford anticipates an influx of members in years to come.

"Association membership is not dying," he says, in fact, county and state medical societies are getting stronger." Nor is that strength offset by the growth of the specialty societies.

"There will have to be a continuing realignment of roles if we are to avoid becoming irrelevant members . . ."

"There are enough variances of purpose to allow each of us to attract members," he says. "The specialty societies play an educational role. That's their obvious function. The medical associations, like the OSMA, however, assume more of an economic and political role. There is some overlap, though, and that is healthy."

As he explains, there are issues of a political nature that are "common to all of us as physicians, no matter what our specialty." That's where the OSMA takes a leadership role.

"The OSMA has demonstrated itself to be effective in the political arena," says Dr. Ford, and, as he sees it, this is one area where the Association membership's strength lies.

"But, as the OSMA and the specialty societies identify their goals, you will see more of a division of responsibilities take place. There will have to be a continuing realignment of roles, if we are to avoid becoming irrelevant members.

Not that, on a broader spectrum, Dr. Ford sees competition as necessarily bad. The wave of competition and marketing that swept in with the Reagan Administration is definitely a "more agreeable alternative than the regulation that preceded it."

"But 'marketing and competition' will not be without regulation of its own," Dr. Ford warns, and, of course, government regulation has not really stopped.

"As the federal government decreases its regulations, the state governments have increased theirs — but that game plan can be changed at any minute," Dr. Ford says with an uncharacteristic cynicism.



OSMA's new President, C. Douglass Ford, M.D., Toledo, is caught in a characteristic pose.

"That's why physicians ought to be involved in the political process. We can have a growing voice in the government's future plans for health care only if we continue to demonstrate our interest and expertise."

Dr. Ford's usual optimism drops a bit, like the guard of a weary fighter, when he discusses how government and other economic groups have affected physician image in the community.

Physicians have been given a bum rap," he says. "Too often we have been held responsible for the leap in the costs of health care," when, he feels, that responsibility might more appropriately lie with the contracts signed by management and labor in the large organizations.

"Quality health care may be costly but it has been the politics of labor and management to shift those costs away from the employee's pocket and put them on the insurers. The employers nonetheless blame the doctors, and the hospital administrators for the escalating costs of health care, since they are the ones that pay the premiums. But it is the American people who really decide, and they will decide the cost of health care. It is their decision how much quality care they will purchase."

But, as he points out, the American public as yet has never considered either cutting down the quality or

reducing the delivery of health care as a viable alternative.

"We still live in a society that spends its dollars to succor its wounded. . . that's what I consider a beautiful thermometer of our faith in each other. Sure, there are inequities in our system, but I see no virtue in dwelling on them alone. As I see it, it's a system that works, and one that can be made to work better." Similarly the OSMA has been working, all along, to enhance that system.

"Our job is attending to the health of our neighbors. That's our reason for being," Dr. Ford says, "but in order to take care of their health, we have to be available."

That's where the OSMA comes in. By providing necessary services — as well as benefits — physician-members are freed to spend more time with their patients, in an environment that is reasonably stable.

Dr. Ford talks about those services which have already been established by his predecessors.

One of the most important steps was taken by those who helped establish PICO: Dr. Jim Henry, Dr. William Wells, Dr. George Bates, Dr. John Gaughan and others. Dr. Ford identifies the establishment of PICO as a turning point for the Association. "At that point we intensified the focus of our Association on the socioeconomic concerns of our members."

Dr. Dunsker's work on developing the IRA, Dr. Thomas' work that resulted in the student membership, based on Dr. Morgan's excellent membership drive, all have established a groundwork on which it is easy to build." Then there is Dr. Wells and Dr. Dunsker's collaboration in developing the group medical liability plan.

One of Dr. Ford's ideas for laying his own groundwork is to utilize some of the heretofore unknown talents of OSMA members.

"There are a lot of members out there who are skilled in areas other than medicine, and this year we hope to find them and use their talents to benefit others in the Association. I have asked the auxiliary to do that research for us."

In a way, Dr. Ford is himself the product of a talent search. As a freshman delegate to the OSMA, he was "brought along" by Fred Osgood, M.D., and Robert Smith, M.D.

"They were the ones who were responsible for my involvement in organized medicine. They encouraged me."

It's an involvement that's taken off in many directions. He is a past president of the American Heart Association of Northwestern Ohio, on the Advisory Committee on Graduate Nursing Education at the Medical College of Ohio, and an active member of numerous medical and community organizations including the Society of Nuclear Medicine and the New York Academy of Sciences.

How does he do it all? It's that gift — that warm, wonderful sense of humor that keeps everything in his life moving smoothly.

"People **need** to face life with humor," Dr. Ford confides. "When Betsy (Dr. Ford's wife) says my pomp is showing, I know it's time to lighten up."

And, like the wheel that's been greased — humor just makes the trip that much more enjoyable along the way.

Karen S. Edwards is Executive Editor of the Ohio State Medical Journal.

PROCEEDINGS OF THE 1982 ANNUAL MEETING OF THE OSMA HOUSE OF DELEGATES

Minutes of the First Session

The first session of the House of Delegates of the Ohio State Medical Association was convened at 7 PM, Friday, April 30, 1982, at Stouffer's Dayton Plaza Hotel, Dayton, with President Stewart B. Dunsker, M.D., presiding.

The invocation was offered by Dr. Leslie Earl Whitmire, Toledo.

Dr. Dunsker introduced Goodwin Berquist, Ph.D., Department of Communications, The Ohio State University, the parliamentarian retained in accordance with Resolution No. 1-76.

Dr. John H. Boyles, Jr., Dayton, President of the Montgomery County Medical Society, welcomed the delegates, alternates and guests to Dayton.

REPORT OF THE CREDENTIALS COMMITTEE

Dr. Theodore J. Castele, Cleveland, Chairman of the Credentials Committee, reported that of 198 members eligible to attend and vote, 149 were present, credentialed and seated. A number of alternate delegates, guests, officers of county medical societies, and executives were in attendance.

1981 MINUTES APPROVED

The minutes of the 1981 sessions of the House of Delegates, as published in the July 1981 issue of *The Ohio State Medical Journal*, were approved by official action.

INTRODUCTION OF OTHERS AT SPEAKERS' TABLE

Dr. Dunsker introduced others seated at the speakers' table, who had not been previously introduced, as follows: C. Douglass Ford, M.D., President-Elect; Robert G. Thomas, M.D., Immediate Past President; David A. Barr, M.D., Secretary-Treasurer; James E. Pohlman, Esq., OSMA Legal Counsel; Hart F. Page, CAE, Executive Director; and Herbert E. Gillen, Deputy Executive Director.

INTRODUCTION OF OSMA PAST PRESIDENTS

The following past presidents of the Association were introduced: Dr. Carl A. Lincke, Carrollton; Dr. Charles L. Hudson,

Bratenahl; Dr. Richard L. Meiling, Columbus; Dr. Theodore L. Light, Dayton; Dr. Robert N. Smith, Toledo; Dr. Oscar W. Clarke, Gallipolis; Dr. James L. Henry, Grove City; Dr. William M. Wells, Newark; Dr. John J. Gaughan, Cleveland; and Dr. Thomas W. Morgan, Gallipolis.

INTRODUCTION OF PAST MEMBERS OF THE OSMA COUNCIL

Dr. Dunsker then introduced former members of the Council: Dr. Theodore J. Castele, Cleveland; Dr. William Dörner, Jr., Akron; Dr. Philip B. Hardyman, Columbus; Dr. Stephen P. Hogg, Cincinnati; Dr. W. J. Lewis, Dayton; Dr. C. Edward Pichette, Youngstown; Dr. Robert E. Rinderknecht, Daphne, Alabama; and Dr. George J. Schroer, Sidney.

OTHER GUESTS INTRODUCED

Dr. Dunsker introduced the following: Dr. John H. Ackerman, Columbus, Director, Ohio Department of Health; Jane C. Lee, Esq., Chicago, Illinois, AMA Medical Society Relations Department; AMA Past Presidents Drs. John H. Budd, Cleveland and Charles L. Hudson, Bratenahl; Dr. W. J. Lewis, Dayton, Member of the AMA Board of Trustees; Dr. Thomas A. Helmuth, Columbus, Vice Chancellor of Health Affairs, Ohio Board of Regents; and Dr. Evelyn L. Cover, Columbus, President, Ohio State Medical Board.

PICO REPORT

Dr. Dunsker then introduced Dr. William M. Wells, Newark, Chairman of the Board of Directors, Physicians Insurance Company of Ohio. Dr. Wells gave a report on the current status of the company and a summary of the activities and accomplishments of PICO in 1981, plus future plans of the company.

REPORT OF OSMA AUXILIARY PRESIDENT

Mrs. Shirley C. Davies, Troy, President of the Ohio State Medical Association Auxiliary, was escorted to the podium by her husband, Dr. A. Robert Davies. She addressed the House of Delegates and reported on 1981 activities of the Auxiliary.

PRESENTATION OF SPECIAL AWARD

Dr. Oscar W. Clarke, Gallipolis, Chairman of the Ohio Delegation to the American Medical Association, escorted Dr. Richard L. Meiling, Columbus, Consultant to *The Ohio State Medical Journal*, and Mrs. Meiling to the podium. Dr. Meiling was presented with a plaque for his many services to the Journal and the Association. Dr. Dunsker presented roses to Mrs. Meiling. Dr. Meiling addressed the House.

AMA/AMERICAN BAR ASSOCIATION AWARD

Dr. Dunsker introduced Dr. W. J. Lewis, Dayton, a Member of the AMA Board of Trustees. Dr. Lewis advised the House that the Academy of Medicine of Cleveland had been given an award by the American Medical Association/American Bar Association for its medicolegal program, which won first place. Drs. Robert M. Zollinger, Jr., and Karl S. Alfred accepted the award on behalf of the Academy.

AMA-ERF CHECKS PRESENTED

Dr. Philip B. Hardyman, Columbus, Chairman of Ohio's Committee for the American Medical Association's Education and Research Foundation (AMA-ERF) was introduced, as was Mrs. Shirley C. Davies, President of the OSMA Auxiliary. Mrs. Davies assisted Dr. Hardyman in the presentation of the AMA-ERF checks to Ohio's six medical schools.

Dr. William D. Sawyer, Dean, Wright State University School of Medicine, thanked the OSMA and the Auxiliary for the AMA-ERF contributions, on behalf of Ohio's six medical schools.

It was announced that these contributions totaled \$57,679.84. Dr. Dunsker expressed thanks on behalf of the Association to Dr. Hardyman and to the OSMA Auxiliary.

CERTIFICATES OF APPRECIATION

The following members of Standing Committees and chairmen of Special Committees of the Association received certificates of appreciation for past service:

Dr. Victor C. Laughlin, Cleveland, Committee on Art and Culture; Dr. Alford

C. Diller, Van Wert, Committee on Auditing and Appropriations; Dr. Ronald Berggren, Columbus, Committee on Communications; Dr. Leonard K. Smith, Kenton, Committee on Communications; Mrs. Linda Porterfield, Columbus, Committee on Communications; Dr. D. James Hickson, Mt. Gilead, Committee on Education and Committee on Judicial and Professional Relations; Dr. John A. Devany, Toledo, Committee on Judicial and Professional Relations; Dr. H. Judson Reamy, New Philadelphia, Committee on Judicial and Professional Relations; Dr. John J. Gaughan, Cleveland, Committee on Membership; Dr. Edward E. Grable, Canton, Committee on Membership; Dr. William M. Wells, Newark, Committee on Membership; and Dr. James B. Daley, Cleveland, Committee on Program.

Dr. S. Baird Pfahl, Jr., Sandusky, Chairman of the Committee on Auditing and Appropriations and the Auxiliary Advisory Committee; Dr. Alford C. Diller, Van Wert, Advisor to the Medical Assistants and Chairman of the Medical Services Review Committee; Dr. Harry H. Fox, Cincinnati, Chairman, Committee on Art and Culture; Dr. Thomas R. Leech, Lima, Chairman, Committee on Communications; Dr. Anthony Ruppertsberg, Jr., Columbus, Chairman, Committee on Maternal and Neonatal Health; Dr. Max D. Graves, Springfield, Chairman, Committee on Mental Health; Dr. Brady F. Randolph, Jr., Hamilton, Chairman, Joint Advisory Committee on Sports Medicine; Dr. A. Burton Payne, Ironton, Chairman, Committee on State Legislation; and Dr. William E. Sovik, Poland, Chairman, Committee on Health Manpower.

Certificates of appreciation were presented to the Co-Chairmen of the Ohio Voluntary Effort: Drs. Herman I. Abramowitz, Dayton and William M. Wells, Newark.

REFERENCE COMMITTEE CHAIRMEN ANNOUNCED

The following House of Delegates Reference Committee chairmen were introduced by President Dunsker:

Credentials of Delegates — Dr. Theodore J. Castele, Cuyahoga County; Tellers and Judges of Election — Dr. William Blake Selnick, Clermont County; Resolutions Committee No. 1 — Dr. Paul S. Metzger, Franklin County; Resolutions Committee No. 2 — Dr. John P. Anderson, Jr., Licking County; Resolutions Committee No. 3 & President's Address — Dr. Lee J. Vesper, Hamilton County. Several changes in committee personnel were announced.

ELECTION OF COMMITTEE ON NOMINATIONS

The House of Delegates nominated and elected the following persons, one from each district, for the Committee on Nominations: First District — Dr. Carl A. Minning, Clermont County; Second District — Dr. A. Robert Davies, Miami County; Third District — Dr. Joseph Oppenheim,

Allen County; Fourth District — Dr. Jerome Kimmelman, Lucas County; Fifth District — Dr. John J. Gaughan, Cuyahoga County; Sixth District — Dr. Raymond J. McMahon, Jr., Stark County; Seventh District — Dr. Carl A. Lincke, Carroll County; Eighth District — Dr. James L. Barrett, Fairfield County; Ninth District — Dr. Thomas P. Price, Jr., Gallia County; Tenth District — Dr. H. William Porterfield, Franklin County; Eleventh District — Dr. Luther W. High, Holmes County; Twelfth District — Dr. W. Paul Kilway, Summit County.

Dr. Dunsker announced that under the system of rotation approved by the House of Delegates in 1963, the chairman of the Committee this year would be the delegate from the Ninth District, Dr. Thomas P. Price, Jr., Gallia County.

PRESIDENT'S ADDRESS

Mr. Page then introduced President Stewart B. Dunsker, Cincinnati, who delivered his Presidential Address.

Dr. Dunsker received a standing ovation.

INTRODUCTION OF OUT-OF-STATE GUESTS

Dr. Dunsker introduced the following out-of-state guests: Indiana State Medical Association — Dr. Martin J. O'Neill, Valparaiso, Indiana, President; Dr. Peter R. Petrich, Attica, Indiana, Floor Leader of the Indiana Delegation to the AMA; and Mr. Donald F. Foy, Indianapolis, Indiana, Executive Director. Illinois State Medical Society — Dr. Cyril C. Wiggishoff, Chicago, Illinois, President and Dr. Robert P. Johnson, Springfield, Illinois, President-Elect. Kentucky Medical Association — Dr. Ballard W. Cassady, Pikeville, Kentucky, President, and Mrs. Cassady. West Virginia State Medical Association — Dr. Harry Shannon, Parkersburg, West Virginia, President-Elect, and Mrs. Shannon.

INTRODUCTION OF REPRESENTATIVES OF ALLIED ORGANIZATIONS

Dr. Dunsker introduced the following representatives of allied organizations: Mr. Herman N. Menapace, Chairman of the Board, Ohio Hospital Association, and Mrs. Menapace; Ms. Jan M. Ellerhorst, representing the Ohio Nurses Association; Milan Gorby, President-Elect, Ohio State Pharmaceutical Association; Mrs. Libby Moore, President, Ohio State Society of Medical Assistants; Mrs. Shirley C. Davies, President and Mrs. Rose Vesper, President-Elect, Ohio State Medical Association Auxiliary.

INTRODUCTION OF MEMORIAL RESOLUTION

The following memorial resolution was introduced by Dr. Brady F. Randolph, Jr., Hamilton, Chairman, Joint Advisory Committee on Sports Medicine:

MEMORIAL RESOLUTION

Sol Maggied, M.D.

WHEREAS, Sol Maggied, M.D. died on

March 18, 1982; and

WHEREAS, A patient of Dr. Maggied who writes a column for the *Columbus Citizen-Journal* summarized the feelings of this dedicated physician's patients as follows:

"Few physicians more than Sol Maggied embraced so intensely the spirit of the Hippocratic oath. Surely few gave more freely of their skills or the money earned by their talent" and

WHEREAS, Dr. Maggied served as president of the Madison County Medical Society for many years; and WHEREAS, Dr. Maggied represented his county for more than 25 years as delegate to the OSMA House of Delegates — often referred to fondly by Dr. Maggied as the "body politic," and

WHEREAS, Dr. Maggied was a charter member of the Joint Advisory Committee on Sports Medicine of OSMA and the Ohio High School Athletic Association, and

WHEREAS, Dr. Maggied served with distinction as chairman of the Joint Advisory Committee on Sports Medicine from 1969 to 1974, and during this time inspired the development of a mandatory, four-day conditioning period at the opening of fall football practice for Ohio high schools, and

WHEREAS, Dr. Maggied coordinated medical coverage for scholastic athletic playoffs in the Columbus and Central Ohio areas — and for state playoffs at The Ohio State University, and

WHEREAS, In 1976 Dr. Maggied was presented the second-ever Special Award for Outstanding Contribution To Sports Medicine in Ohio during the annual Hall of Fame Banquet of the Ohio High School Football Coaches Association, and

WHEREAS, At the time of his death, Dr. Maggied was spearheading a major effort to upgrade interscholastic wrestling rules to further protect the health of participants in this most physical activity, and

WHEREAS, The results of his final "labor of love" will soon come to pass in the form of wrestling guidelines for physicians and coaches, plus rules changes for weight loss and weight categories, therefore be it

RESOLVED, That the Ohio State Medical Association, through Dr. Maggied's "body politic," express its admiration and deepest appreciation for Dr. Maggied's numerous contributions and accomplishments as his "labors of love" during more than 35 years of practice and service to organized medicine. Deepest sympathies are extended to Dr. Maggied's daughter, Dee, sons Doug and Dennis, their families, many friends, and patients.

After the introduction of this resolution, members of Dr. Maggied's family were introduced.

The rules were waived and the resolution was taken up for immediate consideration

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References: 1. Williams RL, Karacan I: Introduction, chap. 1, in *Sleep Disorders: Diagnosis and Treatment*, edited by Williams RL, Karacan I, Frazier SH. New York, John Wiley & Sons, 1978, p. 2. 2. Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 3. Kales A et al: *JAMA* 241:1692-1695, Apr 20, 1979. 4. Kales A et al: *J Clin Pharmacol* 17:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. 5. Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 6. Kales A et al: *Clin Pharmacol Ther* 19:576-583, May 1976. 7. Kales A, Scharf MB, Kales JD: *Science* 201:1039-1041, Sep 15, 1978. 8. Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc* 27:541-546, Dec 1979. 9. Dement WC et al: *Behav Med* 5(10):25-31, Oct 1978. 10. Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. 11. Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. 12. Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. 13. Zimmerman AM: *Curr Ther Res* 13:18-22, Jan 1971. 14. Kales A, Kales JD: *Pharmacol Physicians* 4(9):1-6, Sep 1970. 15. Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

The Physician's Sleep Glossary

Some common sleep laboratory terms

poly•som•no•graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la•ten•cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af•ter sleep on•set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to•tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.¹

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.²

re•bound in•som•nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.³

Efficacy objectively demonstrated in the sleep laboratory—the most valid environment for measuring hypnotic efficacy.

In numerous sleep laboratory investigations patients fell asleep sooner, slept longer and woke up less during the night³⁻¹² with

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The efficacy of Dalmane has been studied in over 200 clinical trials with more than 10,000 patients.³⁻¹⁵ During long-term therapy, which is rarely required, periodic blood, kidney and liver function tests should be performed. Contraindicated in patients who are pregnant or hypersensitive to flurazepam.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, light-headedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



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and was adopted by a standing vote of the members of the House of Delegates.

INTRODUCTION OF RESOLUTIONS

Dr. Dunsker announced that because the resolutions had been printed and distributed to the members of the House prior to the meeting and the assignment of resolutions to the Resolutions Committees had also been presented to the House in writing, individual introduction of the resolutions would be waived unless there were objections voiced by the House. There were none and the reading of the resolutions was waived.

COMMITTEE ON EMERGENCY RESOLUTIONS REPORT

The Committee on Emergency Resolutions met earlier on April 30 to consider two emergency resolutions, as follows: (1) "Protocol for Emergency Medical Services Personnel," introduced by Richard B. Frattianne, M.D., Cuyahoga County; and (2) "The Ohio State Medical

Hall of Fame," introduced by the First District Delegation.

The committee decided that both resolutions would fall in the emergency category and were approved for submission to the House.

The report was filed by action of the House and the resolutions were numbered and referred as follows:

Protocol for Emergency Medical Services Personnel, numbered 39-82, was referred to Resolutions Committee No. 2, and The Ohio State Medical Hall of Fame, numbered 40-82, was referred to Resolutions Committee No. 3.

ACTION REPORT ON 1981 RESOLUTIONS

Dr. Dunsker announced that a report on the "follow-up" work on 1981 Resolutions had been distributed to the Delegates and Alternates prior to the First Session.

HOUSE RECESSED

The House then recessed until the final session, 1:00 PM, Sunday, May 2.

PRACTICE OPPORTUNITIES

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MINUTES OF THE SECOND SESSION OF THE HOUSE OF DELEGATES

MINUTES OF THE FINAL SESSION

The final session of the House of Delegates was convened at 1:00 PM, Sunday, May 2, at Stouffer's Dayton Plaza Hotel, Dayton, with President Stewart B. Dunsker, M.D., presiding.

PRESENTATION OF ART AND PHOTOGRAPHIC AWARDS

The 1982 Ohio State Medical Journal Art & Photographic Exhibit awards were presented by Dr. Harry H. Fox, Cincinnati, Chairman of the OSMA Committee on Art and Culture, and D. James Hickson, Mt. Gilead, a member of this committee.

REPORT OF THE CREDENTIALS COMMITTEE

Dr. Theodore J. Castele, Cleveland, Chairman of the Credentials Committee, reported that out of 199 delegates eligible to vote, 174 were present, credentialed and seated.

ELECTION OF PRESIDENT-ELECT

Dr. Dunsker called for nominations for the office of President-Elect.

Dr. John A. Devany, Toledo, placed in nomination Dr. Alford C. Diller, Van Wert, Van Wert County. The nomination was seconded by Dr. Richard J. Nowak, Cleveland. Dr. Thomas W. Morgan, Gallipolis, placed in nomination Dr. S. Baird Pfahl, Jr., Sandusky, Erie County. Dr. A. Burney Huff, Wooster, seconded the nomination. There were no other nominations and a written ballot was taken. Dr. Pfahl was elected. Dr. Pfahl then addressed the House.

REPORT OF NOMINATING COMMITTEE

Dr. Thomas P. Price, Jr., Delegate, Gallia County, Chairman of the Nominating Committee, presented the report of the Committee on Nominations, as follows:

Secretary-Treasurer

The Committee on Nominations presented the name of one candidate for Secretary-Treasurer, the incumbent, Dr. David A. Barr, Lima, Allen County. There were no nominations from the floor and Dr. Barr was re-elected by acclamation.

Councilors

First District: As Councilor of the First District, to succeed himself, Dr. John E. Albers, Cincinnati, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Albers was declared

reelected Councilor of the First District for a term of two years, 1982-1984.

Third District: As Councilor of the Third District to succeed Dr. Alford C. Diller, Van Wert, the Committee placed in nomination Dr. Thomas R. Leech, Lima. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Leech was declared elected Councilor of the Third District for a term of two years, 1982-1984.

Fifth District: As Councilor of the Fifth District, to succeed himself, Dr. Edward G. Kilroy, Cleveland, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Kilroy was declared reelected Councilor of the Fifth District for a term of two years, 1982-1984.

Seventh District: As Councilor of the Seventh District, to succeed himself, Dr. H. Judson Reamy, New Philadelphia, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Reamy was declared reelected Councilor of the Seventh District for a term of two years, 1982-1984.

Ninth District: As Councilor of the Ninth District, to succeed himself, Dr. A. Burton Payne, Ironton, was nominated. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Payne was declared reelected Councilor of the Ninth District for a term of two years, 1982-1984.

Eleventh District: As Councilor of the Eleventh District to succeed Dr. S. Baird Pfahl, Jr., Sandusky, the Committee placed in nomination Dr. D. Ross Irons, Bellevue. The nomination being duly seconded and there being no further nominations from the floor, by official action the nominations were closed and Dr. Irons was declared elected Councilor of the Eleventh District for a term of two years, 1982-1984.

AMA Delegates

Dr. Price then presented the nominees for the office of Delegate to the American Medical Association to fill a term beginning January 1, 1983 and ending December 31, 1984 (7 to be elected): Drs. Theodore J. Castele, Cleveland; Alford C. Diller, Van Wert; William Dörner, Jr., Akron; Stewart B. Dunsker, Cincinnati; Edward E. Grable, Canton; Jerry L. Hammon, Dayton; H. William Porterfield, Columbus; Jack Schreiber, Canfield; Robert N. Smith, Toledo; and Robert G. Thomas, Elyria. The nominations were duly seconded and there

were no further nominations from the floor. A written ballot was taken and Drs. Castele, Dunsker, Hammon, Porterfield, Schreiber, Smith and Thomas were declared elected.

The nominees for Delegates to the American Medical Association to serve a term beginning May 2, 1982 and ending December 31, 1982, were presented by Dr. Price (2 to be elected): Drs. Stewart B. Dunsker and Robert G. Thomas (the new delegates elected by the previous election). Drs. Dunsker and Thomas were elected by acclamation.

Dr. Price announced the nominees for Delegate to the American Medical Association to serve a term beginning May 2, 1982 and ending December 31, 1983 (2 to be elected): Dr. Alford C. Diller, Van Wert; Dr. William Dörner, Jr., Akron; and Dr. Edward E. Grable, Canton. The nominations were duly seconded and there were no further nominations from the floor. A written ballot was taken and Drs. Diller and Dörner were declared elected.

AMA Alternates

For Alternate Delegate to the American Medical Association to fill a term beginning January 1, 1983 and ending December 31, 1984, the nominees were (7 to be elected): Drs. James E. Barnes, Columbus; David A. Barr, Lima; Donavin A. Baumgartner, Jr., Cleveland; Ronald B. Berggren, Columbus; John H. Boyles, Jr., Dayton; A. Robert Davies, Troy; Kenneth Frederick, Cincinnati; Roland A. Gandy, Jr., Toledo; Ray W. Gifford, Cleveland; Douglas S. Hess, Bowling Green; Edward G. Kilroy, Cleveland; Jerome Kimmelman, Toledo; Stanley J. Lucas, Cincinnati; Richard J. Nowak, Cleveland; H. Judson Reamy, New Philadelphia; Benjamin H. Reed, Wauseon; Carl E. Spragg, New Concord; Joseph Sudimack, Jr., Warren; Lee J. Vesper, Cincinnati; and Claire V. Wolfe, Columbus. The nominations were duly seconded and there were no further nominations from the floor. A written ballot was taken and Drs. Davies, Gandy, Gifford, Kilroy, Spragg, Sudimack and Wolfe were declared elected.

The nominees for Alternate Delegate to the American Medical Association to serve a term beginning May 2, 1982 and ending December 31, 1982, were presented by Dr. Price (5 to be elected): Drs. Davies, Gifford, Spragg, Sudimack and Wolfe, the new alternate delegates elected by the previous election, were elected by acclamation.

Dr. Price announced the nominees for Alternate Delegate to the American Medical Association to serve a term beginning May 2, 1983 and ending December 31, 1983 (3 to be elected): Drs. James E. Barnes, Columbus; David A. Barr, Lima; Donavin

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REPORT OF RESOLUTIONS COMMITTEE NO. 1

Dr. Paul S. Metzger, Franklin County, as chairman, presented the report of Resolutions Committee No. 1:

Mr. President and members of the House of Delegates. Resolutions Committee No. 1 met in open session on May 1, 1982 and heard testimony on Resolutions 1-82 through 14-82 with exception of Resolution 5-82 which was withdrawn, and Report B.

RESOLUTION 1-82 OSMA Committees

Testimony on this resolution was favorable. The Committee however was of the opinion that the limit of two consecutive one year appointments for the Committee Chairman was restrictive and could result in loss of talented individuals prematurely.

The Committee proposes that the first paragraph of Section 2 in the Resolved portion of Resolution 1-82 be amended to read as follows:

WHEREAS, OSMA Council believes that revision of the OSMA Bylaws to provide the opportunity for more members to become involved in OSMA activities, it recommends for adoption by the House of Delegates the following:

RESOLVED, That the OSMA Bylaws, Chapter 9 ("Committees"), Section 2 ("Appointments") to be amended to provide as follows:
Section 2. Appointment. The President with approval of Council shall appoint the chairman and members of each standing and special committee. EACH COMMITTEE CHAIRMAN SHALL SERVE A ONE YEAR TERM, AND MAY SERVE A MAXIMUM OF ~~TWO~~ **THREE** CONSECUTIVE ONE YEAR APPOINTMENTS. A COMMITTEE CHAIRMAN WHO HAS SERVED ~~TWO~~ **THREE** ONE YEAR APPOINTMENTS IS ELIGIBLE FOR REAPPOINTMENT AS CHAIRMAN AFTER ONE YEAR. THE LIMITATIONS ON YEARS OF SERVICE AS CHAIRMAN SHALL NOT AFFECT THE MEMBER'S RIGHT TO BE APPOINTED TO SERVE ON ANY COMMITTEE.

EACH COMMITTEE MEMBER SHALL BE APPOINTED FOR A TWO YEAR TERM, except for the first

appointments at which time one-half of the committee shall be appointed for one year and one-half of the committee shall be appointed for two years. EACH COMMITTEE MEMBER IS LIMITED TO THREE CONSECUTIVE TWO YEAR TERMS ON ANY ONE COMMITTEE. A MEMBER HAVING SERVED THE MAXIMUM OF THREE CONSECUTIVE TWO YEAR TERMS IS ELIGIBLE FOR REAPPOINTMENT TO SUCH COMMITTEE AFTER ONE YEAR. A MEMBER MAY SERVE ON MORE THAN ONE COMMITTEE SIMULTANEOUSLY. IF A VACANCY OCCURS IN ANY COMMITTEE, the president with approval of Council, MAY fill the vacancy for the remainder of the term.

Mr. President, I move the adoption of Resolution 1-82 as amended.

By official action, the House voted to adopt Resolution 1-82, as amended by the Committee.

RESOLUTION 2-82 OSMA Committees

No oral testimony was offered on this resolution. An explanation of the intent of the resolution was circulated. The Committee, by consensus, felt that this resolution's intent was already being accomplished by Amended Resolution 3-81 passed at the 1981 Annual Meeting.

The Committee recommends rejection of Resolution No. 2-82.

By official action, the House voted to reject Resolution No. 2-82.

Continued on page 487

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Inderal[®] BRAND OF propranolol hydrochloride A beta-adrenergic blocking agent

BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

CONTRAINDICATIONS

INDERAL is contraindicated in 1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL, 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta-blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. INDERAL acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by INDERAL's negative inotropic effect. The effects of INDERAL and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during INDERAL therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) If cardiac failure continues, despite adequate digitalization and diuretic therapy, INDERAL therapy should be immediately withdrawn. b) If tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of INDERAL therapy. Therefore, when discontinuation of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS DURING ANESTHESIA with agents that require catecholamine release for maintenance of adequate cardiac function, beta blockade will impair the desired inotropic effect. Therefore, INDERAL should be titrated carefully when administered for arrhythmias occurring during anesthesia.

IN PATIENTS UNDERGOING MAJOR SURGERY beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, INDERAL should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since INDERAL is a competitive inhibitor of beta receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA Because of its beta-adrenergic blocking activity, INDERAL may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY The safe use of INDERAL in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit.

Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of INDERAL may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura.

Central Nervous System lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory bronchospasm.

Hematologic agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Miscellaneous reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

DOSEAGE AND ADMINISTRATION

ORAL

HYPERTENSION Dosage must be individualized. The usual initial dosage is 40 mg INDERAL twice daily, whether used alone or added to a diuretic. Dosage may be increased gradually until adequate blood pressure is achieved. The usual dosage is 160 to 480 mg per day. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

While twice-daily dosing is effective and can maintain a reduction in blood pressure throughout the day, some patients, especially when lower doses are used, may experience a modest rise in blood pressure toward the end of the 12 hour dosing interval. This can be evaluated by measuring blood pressure near the end of the dosing interval to determine whether satisfactory control is being maintained throughout the day. If control is not adequate, a larger dose, or 3 times daily therapy may achieve better control.

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

INTRAVENOUS

The intravenous administration of INDERAL has not been evaluated adequately in the management of hypertensive emergencies.

OVERDOSAGE OR EXAGGERATED RESPONSE

IN THE EVENT OF OVERDOSAGE OR EXAGGERATED RESPONSE, THE FOLLOWING MEASURES SHOULD BE EMPLOYED:

BRADYCARDIA—ADMINISTER ATROPINE (0.25 to 1.0 mg) IF THERE IS NO RESPONSE TO VAGAL BLOCKADE. ADMINISTER ISOPROTERENOL CAUTIOUSLY.

CARDIAC FAILURE—DIGITALIZATION AND DIURETICS.

HYPOTENSION—VASOPRESSORS, e.g., LEVATERENOL OR EPINEPHRINE (THERE IS EVIDENCE THAT EPINEPHRINE IS THE DRUG OF CHOICE).

BRONCHOSPASM—ADMINISTER ISOPROTERENOL AND AMINOPHYLLINE.

HOW SUPPLIED

TABLETS INDERAL (propranolol hydrochloride)

No. 461—Each scored tablet contains 10 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 462—Each scored tablet contains 20 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 464—Each scored tablet contains 40 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 468—Each scored tablet contains 80 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

INJECTABLE

No. 3265—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10.

Reference: 1. Freis, E. D. Hypertension (Suppl. II) 3:230 (Nov-Dec.) 1981

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Minutes of the Second Session (continued)

RESOLUTION 4-82 Annual Meeting Format

RESOLUTION 7-82 Weekend Meetings of the OSMA

The two resolutions were considered together because of their commonality. The Committee proposes the combining of these resolutions into Substitute Resolution 4-82 as follows:

SUBSTITUTE RESOLUTION 4-82

WHEREAS, The Resolution No. 12-81 states that

"RESOLVED, That the Annual Meeting of the House of Delegates of the Ohio State Medical Association be scheduled as soon as practical, as follows:

"The opening session of the House of Delegates will begin on Thursday A.M. and the closing session of the House of Delegates will begin by noon on Saturday."; and

WHEREAS, the 1982 House of Delegates format is modified to Friday, Saturday and Sunday, because facilities were not available to comply with Resolution No. 12-81; and

WHEREAS, The OSMA Council, after discussion, deems the 1982 House of Delegates weekend format reasonable; therefore be it

RESOLVED, That as soon as practically possible, realizing the constraints of advanced reservation problems, the Ohio State Medical Association Annual Meeting be scheduled on weekends, from Friday through Sunday for three years beginning with the 1982 meeting and that an evaluation of the Friday-Sunday format be reported to the House of Delegates/ AT THE ANNUAL MEETING IN 1984.

By official action, *the House voted to amend and adopt Substitute Resolution No. 4-82. The amendment is indicated in capital letters.*

RESOLUTION 6-82 Annual Meeting, OSMA

This resolution was presented primarily as a cost-saving measure on the assumption that having meetings in Columbus would reduce the costs of transporting and providing for staff personnel when held outside of Columbus.

However, available information shows that very little reduction in expenses would accrue from holding all meetings in Columbus. Therefore, the Committee recommends that Resolution 6-82 be rejected.

By official action, *The House voted to reject Resolution No. 6-82.*

RESOLUTION 8-82 Certification of Delegates of Component Societies

The Committee heard much testimony

opposing this resolution and was of the opinion that many medical societies were concerned that this resolution could conflict with the component medical society representation in the House of Delegates and therefore recommends Resolution 8-82 be rejected.

By official action, *the House voted to reject Resolution No. 8-82.*

RESOLUTION 10-82 Establishment of a Resident Physician's Section Within the OSMA

The Committee heard no testimony in support of Resolution 10-82 as submitted. There was a definite consensus for increasing resident physician participation in organized medicine at the county, state, and national levels. The Committee therefore, proposes the adoption of Substitute Resolution 10-82 as follows:

SUBSTITUTE RESOLUTION 10-82 ESTABLISHMENT OF A RESIDENT PHYSICIAN'S COMMITTEE WITHIN THE OSMA

WHEREAS, Resident physicians now make up an increasing percentage of OSMA membership, and

WHEREAS, Resident physicians frequently have specific concerns and problems differing from those of physicians in practice, and

WHEREAS, The input and participation of resident physician members is desirable and should be encouraged at all levels of organized medicine, and

WHEREAS, The Resident Section of the AMA has become increasingly active and effective, therefore be it
RESOLVED, That OSMA House of Delegates direct Council to establish a Committee made up of resident physicians from hospitals with an approved residency training program which would meet at least once a year for purposes of discussing the concerns and problems of resident physicians, as well as providing a means of formulating appropriate resolutions for presentation to the OSMA House of Delegates, and be it further

RESOLVED, That the Chairman of the Resident Committee be invited to attend regular Council meetings as a guest, and be it further

RESOLVED, That all Districts with counties having resident members be urged to include within their OSMA delegation, resident physicians appointed or elected according to the method of each county organization, and be it further

RESOLVED, That resident representation from the OSMA be actively encouraged in the AMA Resident Section according to the representation formula of that organization and that participation be fostered by providing travel reimbursement for such resident

representatives to the AMA meetings in an amount to be determined by

Council and, Mr. President, I so move.
By official action, *the House voted to adopt Substitute Resolution No. 10-82.*

RESOLUTION 11-82 Medical Specialty Society Representation

The Committee heard approximately equal testimony for and against specialty representation but was persuaded by the perception that many of those testifying were in favor of exploring techniques to increase membership and obtain specialty society views. The Committee therefore, submits amended Resolution 11-82 as follows:

AMENDED RESOLUTION 11-82 — MEDICAL SPECIALTY SOCIETY REPRESENTATION

BE IT RESOLVED, That the Bylaws of the Ohio State Medical Association be amended to provide for Medical Specialty representation in the House of Delegates as follows:

Chapter 4. The House of Delegates
Section 3. Representation of Medical
Specialties.

~~A Medical Specialty defined as an organization that has an established medical section in OSMA is eligible to apply for representation in the House of Delegates.~~

ALL PRIMARY MEDICAL SPECIALTIES LISTED BY THE AMERICAN BOARD OF MEDICAL SPECIALTIES ARE ELIGIBLE TO APPLY FOR REPRESENTATION IN THE HOUSE OF DELEGATES.

To be eligible, the specialty society or societies in the section initially must have 50% of their physicians as members of the OSMA; at the end of its third year of representation, 75% OSMA membership has to be achieved. If for 3 consecutive years thereafter this percentage is not maintained, then delegate status is ~~subject to removal.~~ TERMINATED.

A Medical Specialty Section seeking representation shall apply to the Council. The Council shall consider applications and then recommend to the House of Delegates whether the specialty society qualifies for representation.

Each recognized Medical Specialty Section shall have one delegate and alternate who must be members of the Ohio State Medical Association. Each specialty section will certify to the Association at least 60 days prior to the Annual Meeting both the names of its delegate and alternate, and its membership certification as required by subsection (b) above. A Medical Specialty Section delegate shall have all rights, privileges and duties as other delegates. The delegate will be seated

in the House of Delegates with the councilor district in which his/her county medical society is represented. Failure to comply with Section 3, Chapter 4 shall result in loss of representation. That determination shall be made by the Council, with appeal provided to the House of Delegates; and be it further

RESOLVED, That the remaining sections of Chapter 4 be renumbered accordingly beginning with Quorum as Section 4; and be it further

RESOLVED, That in case of conflict as to which state organization most completely represents a recognized specialty, the final decision rests with the House of Delegates of the Ohio State Medical Association.

By official action, the House voted to amend Amended Resolution No. 11-82, and to adopt it. The additions are indicated by capital letters and the deletions by strike-outs.

RESOLUTION 12-82

Authority for OSMA Review Functions

The Committee heard considerable testimony favoring this resolution. However, there were valid concerns expressed about the costs in instituting such a program as well as the implications of pending antitrust cases.

The Committee is of the opinion that this matter deserves further study and investigation including legal consultation.

The Committee recommends Resolution 12-82 be referred to the Council FOR RESEARCH AND STUDY, BUT RETURNED TO THIS HOUSE OF DELEGATES FOR ITS APPROVAL PRIOR TO ANY IMPLEMENTATION, and Mr. President, I so move.

By official action, the House voted to adopt the Committee's recommendation, with an addition, denoted in capital letters, that Resolution 12-82 be referred to the Council. Resolution 12-82 reads as follows:

Whereas, There is a continuing demand for accountability of physician decisions as they affect the economics of the health-care system in Ohio; particularly in institutional settings; and

Whereas, There is an increase in the numbers of proprietary reviewing groups in Ohio; some with, some without adequate physician guidance of their review operations; and

Whereas, Such investigations ought to be educational, rather than punitive in intent or result; and

Whereas, The results of such reviews should be independent and objective even though the costs of such reviews shall be borne by the requestors for reviews; and

Whereas, A review of a physician's professional activity is best accomplished by the physician's colleagues in terms of objectivity, of necessary knowledge, and of an appreciation of the nuances of decision-making in a clinical setting; therefore be it

RESOLVED, That it be the sense of the House of Delegates that all systems of

review which are or which will be established in Ohio ought to have adequate physician guidance over the mechanisms used for review so that the results of such reviews have credibility with the public, as well as with the profession; and be it further

RESOLVED, That, in order to effect the participation and guidance of physicians in the review process, the House of Delegates authorize the O.S.M.A. and its subsidiaries to establish a state-wide reviewing system to:

- 1) act in concert with local or regional groups which do utilize adequate physician expertise in their mechanisms of review
- 2) act as a clearing house for patient, employer, agency, or insurer generated requests for determinations of medical necessity reviews, or for utilization reviews, or for those fee reviews which have a legally acceptable intent in order to avoid anti-trust vulnerability.
- 3) act as the responsible review agency in those instances when a local review agency is not available or when the local review agency does not avail itself of adequate physician guidance over its decision process, or when the officers of a component County Medical Society request such activity.
- 4) act as a source for due-process determinations when requested by a physician member of the O.S.M.A., or by the officers of a component society; and when such an adjudicative role is agreed upon by all of the involved parties.
- 5) Maintain data banks to:
 - a) shape educational programs as indicated by review data
 - b) shape risk-management programs as suggested by review data
 - c) provide factual data for the Association's comments on proposed agency regulations, for comments on proposed legislation (State or Federal), for the Association's public relation efforts, for the use of appropriate O.S.M.A. committee chairmen, and for the use of Council; and be it further

RESOLVED, That safeguards to the access to and the use of the data be such that:

- a) identification of individuals and their medical information is not possible
- b) identification of health care institutions and of individual physicians is not probable
- c) Public Relation uses of the accumulated information will be to provide an accurate image of physician activities
- d) an individual physician member will be granted access to the data for demographic or epidemiologic or other

research purposes as approved by the officers of the O.S.M.A. reviewing system

- e) such other safeguards as may be imposed by the House of Delegates and/or O.S.M.A. council; and be it further

RESOLVED, That such a review system shall be fiscally self-sufficient, and that any funds shall accrue to the O.S.M.A. subsidiary responsible for the operations. Such funds may be distributed by the subsidiary to the O.S.M.A. and to its component societies as prudence governs.

RESOLUTION 13-82 Mandatory CME

The Committee heard testimony on Resolution 13-82, and all comments stated were in support of this resolution. Amended Resolution 7-80 passed at the 1980 Annual Meeting, embodies the identical concepts contained in Resolution 13-82 and which is current OSMA policy. The Committee therefore, recommends that Resolution 13-82 be rejected.

By official action, the House voted to amend Resolution 13-82, and to adopt it. The additions are indicated by capital letters and the deletions by strike-outs. Amended Resolution 13-82 reads as follows:

Whereas, Current Ohio law mandates that all physicians must document that they have completed a prescribed number of hours of continuing medical education (CME) as a requirement for the periodic re-registration of their medical license; and

Whereas, The State's resources are insufficient to monitor and enforce the CME requirement effectively; therefore be it

RESOLVED, That the OSMA ~~recommend that the Ohio General Assembly consider repeal of the legislative Act, Section 1731.281, Ohio Revised Code, that mandates verification of physicians' participation in continuing medical education; and be it further~~

HOUSE OF DELEGATES REAFFIRMS AMENDED RESOLUTION 7-80 WHICH RECOMMENDS TO THE OHIO GENERAL ASSEMBLY THAT THE LEGISLATIVE ACT MANDATING VERIFICATION OF PHYSICIANS' PARTICIPATION IN CME BE REPEALED; AND BE IT FURTHER

RESOLVED, That the OSMA continue to encourage and promote voluntary participation by Ohio physicians in continuing medical education that is relevant to their practices and available from accredited sponsors of CME throughout the State.

RESOLUTION 14-82 Funds for Defense

The Committee heard considerable testimony on the merits of Resolution 14-82. After much deliberation and reviews of previous actions, the Committee believes that there is an adequate mechanism for handling the potential problems involving legal issues.

The Committee recommends rejection of Resolution 14-82.

By official action, the House voted to reject Resolution 14-82.

RESOLUTION 3-82 Bylaw Amendment Procedure

The Committee placed Resolution 3-82 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, OSMa Council believes that revision of the OSMa Bylaws to provide for direct notice to members of proposed changes in the Bylaws are appropriate, it recommends for adoption by the House of Delegates the following:

RESOLVED, That the OSMa Bylaws, Chapter 15 ("Amendments"), Section 1 ("Method of Amending") be amended to provide as follows:

Section 1. Method of Amending. These Bylaws may be amended at any Annual Meeting of the House of Delegates by a majority vote of the delegates present at that session, provided that the proposed amendment shall have been published in *The Journal* OR MAILED TO ALL MEMBERS OF THE ASSOCIATION at least thirty (30) days prior to the Annual Meeting.

By consent, the House adopted Resolution No. 3-82.

RESOLUTION 9-82 Parliamentarian

The Committee placed Resolution 9-82 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, The business of the House of Delegates of the Ohio State Medical Association should proceed with dispatch and proper order without parliamentary mistakes; therefore be it

RESOLVED, That the Ohio State Medical Association provide an accomplished and competent parliamentarian who is well versed in Sturgis Rules of Parliamentary Procedure to insure orderly procedure for each session of the House of Delegates.

By consent, the House adopted Resolution No. 9-82.

REPORT B OSMA Interim Sessions and Update Meetings

The Committee placed Report B on the Consent Calendar and recommended its adoption.

By consent, the House adopted Report B.
THE REPORT OF RESOLUTIONS COMMITTEE NO. 1, AS A WHOLE, AS AMENDED, WAS APPROVED BY THE HOUSE.

REPORT OF RESOLUTIONS COMMITTEE NO. 2

Dr. John P. Anderson, Jr., Licking County, as chairman presented the report

of Resolutions Committee No. 2:

Mr. President and members of the House of Delegates:

Resolutions Committee No. 2 met in open session at 7:30 a.m. on Saturday, May 1, 1982, and heard testimony on Resolutions 15-82 through 25-82, as well as Resolution 39-82.

RESOLUTION 20-82 Participation Agreements Offered by Blue Shield Plans in Ohio

Mr. President, the Committee offers the following amended resolution and I move its adoption:

AMENDED RESOLUTION 20-82 PARTICIPATION AGREEMENTS OFFERED BY BLUE SHIELD PLANS IN OHIO

Whereas, The June, 1978 annual meeting of the House of Delegates, American Medical Association agreed that "each physician should determine for himself what his relationship with his local Blue Shield plan should be."; and

Whereas, That body at its interim session in December, 1980 reaffirmed an earlier Association statement that "the AMA oppose third-party differentiation between covered services provided by participating and nonparticipating physicians as discriminatory against the physician who does not have a separate contractual relationship with the carrier and inhibiting the patient's free choice of physician."; and

Whereas, In the State of Massachusetts it is reported that a lower, co-insurance reimbursement is made to the patient by Blue Shield following his direct payment to the physician (if his physician has not signed a participating agreement with Blue Shield); and

Whereas, Ohio Medical Indemnity, Inc. (Blue Shield of Ohio) has announced the intention of soliciting participating agreements from Ohio physicians by August, 1982 or before and the Cleveland Medical Mutual Insurance Company (Blue Shield affiliated in Cleveland) has for an extended time been soliciting such participating agreements; therefore be it

RESOLVED, That the Ohio State Medical Association opposeS THE CONCEPT OF third-party differentiation between covered services provided by participating and non-participating physicians as discriminatory against PATIENTS, AND THEIR physicians who does not have a separate contractual relationship with the carrier and inhibiting the patient's free choice of physician.

By official action, the House voted to amend Amended Resolution No. 20-82, and to adopt it. The additions are indicated by capital letters and the deletion by a strike-out.

RESOLUTION 21-82 Assignment of Insurance Benefits

Mr. President, the Committee offers the

following amended resolution and I move its adoption:

AMENDED RESOLUTION 21-82 ASSIGNMENT OF INSURANCE BENEFITS

Whereas, Property and casualty insurance carriers have traditionally accepted the right of an insured to assign the payment of a claim to another party who has a legitimate interest in that claim (to the extent of that person's interest in the claim); and

Whereas, Certain health insurance carriers do not honor the right of a covered insured to assign the proceeds of an insurance claim to a physician having a legitimate interest in a claim and refuse to list the physician even as a co-payee when a valid assignment is executed; and

Whereas, This conduct by insurance carriers appears to be coercive and constitutes an interference in the total patient-physician relationship; therefore be it

RESOLVED, That the Ohio State Medical Association seek to persuade insurance carriers to honor a valid assignment of benefits to a party who has a legitimate financial interest in a claim and to either pay the party directly or list the party as a co-payee on the check or draft.

By official action, the House voted to adopt Amended Resolution No. 21-82.

RESOLUTION 23-82 Health Planning Advisory Panels

Mr. President, the Committee offers the following amended resolution and I move its adoption:

AMENDED RESOLUTION 23-82 HEALTH PLANNING ADVISORY PANELS

Whereas, The focus of health planning in Ohio is now at the state, rather than the federal level; and

Whereas, The citizens of Ohio are entitled to quality health care; and

Whereas, The existing complex health care programs directed toward the underserved and medically needy population have contributed to duplication, fragmentation and waste; and

Whereas, There are experts on the provision of quality health care who possess valuable information regarding the health care needs of the citizens of Ohio and the success of existing programs and health care systems; therefore be it

RESOLVED, That the Ohio State Medical Association establish technical advisory panels on health care services and the delivery of such services and that these panels be composed of physicians and other technical experts who have training in the field of health care and who will be available to assist state officials such as the Director of the Department of Health and the

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* Meeting of Am Soc Colon/Rectal Surgeons, May 1980.

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* 1981 data from leading marketing research organization.

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Before prescribing, please see full prescribing information. A Brief Summary follows:

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CONTRAINDICATIONS

Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

WARNINGS

The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

PRECAUTIONS

General

Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

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Pregnancy

See "WARNINGS"

Pediatric Use

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Anusol-HC Suppositories—Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

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Minutes of the Second Session (continued)

Governor in the prioritizing of health care needs and services, review and oversee regulations for existing and new programs, monitor all new health care legislation at the state level and advise on the use of federal funds and the state health budget.

By official action, the House voted to adopt Amended Resolution No. 23-82.

RESOLUTION 24-82

Medical Staff Representation on the Board of Trustees of a Tax Supported Hospital

Mr. President, the Committee offers the following amended resolution and I move its adoption:

AMENDED RESOLUTION 24-82 MEDICAL STAFF REPRESENTATION ON THE BOARD OF TRUSTEES OF A TAX SUPPORTED HOSPITAL

Whereas, The House of Delegates of OSMA at its Annual Meeting in 1979 adopted Amended Resolution 46-79 which stated "Resolved, That the AMA petition the Joint Commission on Accreditation of Hospitals to strengthen the wording in its requirements dealing with hospital boards to assure representation by physician staff members with voting privileges; and Be it Further Resolved, That this resolution be forwarded to every hospital administrator and Board of Trustees in Ohio."; and

Whereas, The Attorney General of the State of Ohio has, on at least three occasions written opinions stating that physicians employed by a county hospital either on a full-time or part-time basis may not serve on the board of trustees of that hospital; and

Whereas, The opinion of the office of the Attorney General is inconsistent with the position of the OSMA; and

Whereas, There is currently a bill, H.B. 8, in the Ohio General Assembly which would require that at least two members of the board of trustees of a county hospital be members of that hospital's medical staff; therefore be it
RESOLVED, That the Ohio State Medical Association support the legislative efforts to either require or permit full voting membership on the board of trustees of a STATE OR county hospital by a member or members of the medical staff of a hospital funded by state or county taxes.

By official action, the House voted to amend Amended Resolution No. 24-82 and adopted it. The amended portion is indicated by capital letters.

RESOLUTION 25-82

The American Student In Foreign Medical Schools

Mr. President, the Committee offers the following amended resolution and I move its adoption:

AMENDED RESOLUTION 25-82 THE AMERICAN STUDENT IN FOREIGN MEDICAL SCHOOLS

Whereas, There has been a recent proliferation of foreign medical schools whose purpose is primarily the education of American citizens for practice in the United States rather than their own nationals; and

Whereas, Many of these schools provide inadequate curricula and insufficient clinical experience for their students; and

Whereas, Attempts to correct deficiencies in clinical experience are made by utilizing the facilities of American hospitals for clinical clerkships; and

Whereas, Many of the various State Medical Boards have no provisions dealing with the adequacy of clinical clerkships for educational purposes or the protection of patients from the inappropriate practice of medicine by such clinical clerks; and

Whereas, In many of the various state jurisdictions the only assessment of the adequacy of the educational program presented by the foreign medical schools is a listing in the 1970 World Health Organization list of medical schools, or the ability of a student to pass the ECFMG examination; therefore be it

RESOLVED, That the Ohio Board of Regents be encouraged to develop standards for the conditions under which students to foreign medical schools function in medical student clinical clerkships offered by hospitals in the State of Ohio which will be equivalent to those offered by medical schools in the United States, and which will clearly delineate the responsibilities of the supervising physician for the actions of the student; and be it further

RESOLVED, That the various State Medical Boards be encouraged to develop standards to assure that foreign medical graduates have received a medical school education substantially equivalent to that received in a U.S. medical school prior to their examination for licensure; and be it further

RESOLVED, That the Ohio State Medical Association urge the American Medical Association to take the lead in stimulating the development of a method of evaluation of foreign medical schools upon request by these foreign medical schools on a national level in conjunction with the Federation of State Medical Examining Boards and the Association of American Medical Colleges; and be it further

RESOLVED, That this resolution be transmitted to the AMA House of Delegates for its consideration.

By official action, the House voted to refer Amended Resolution No. 25-82 to the Council.

RESOLUTION 15-82 Charity Care Tax Credit

The Committee placed Resolution No. 15-82 on the Consent Calendar and

recommended its rejection.

By consent, the House rejected Resolution No. 15-82.

RESOLUTION 16-82

O.S.M.A. and Patient vs. Ohio Welfare Department

The Committee placed Resolution No. 16-82 on the Consent Calendar and recommended its rejection.

The House voted that Resolution No. 16-82 be taken off of the consent calendar, discussed it, then rejected it.

RESOLUTION 17-82

Medical Care Coupons

The Committee placed Resolution No. 17-82 on the Consent Calendar and recommended its rejection.

The House voted that Resolution No. 17-82 be taken off of the consent calendar, discussed it, then rejected it.

RESOLUTION 18-82

Prompt Payment of Insurance Claims

The Committee placed Resolution No. 18-82 on the Consent Calendar and recommended its rejection.

By consent, the House rejected Resolution No. 18-82.

RESOLUTION 19-82

Health Insurance Rates

The Committee placed Resolution No. 19-82 on the Consent Calendar and recommended its rejection.

By consent, the House rejected Resolution No. 19-82.

RESOLUTION 22-82

Physical Therapy Rendered Under the Supervision of a Physician

The Committee placed Resolution No. 22-82 on the Consent Calendar and recommended its rejection.

By consent, the House rejected Resolution No. 22-82.

RESOLUTION 39-82

Protocol for Emergency Medical Services Personnel

The Committee placed Resolution No. 39-82 on the Consent Calendar and recommended referral to the Council.

By official action, the House removed Resolution 39-82 from the consent calendar; voted to amend it as indicated in capital letters, and to refer the Amended Resolution to the Council. The resolution reads as follows:

Whereas, Two physicians in California responded to an emergency situation, and upon arrival of the Emergency Medical Services personnel, were ordered away from the patient and were subsequently physically removed by the police, and

Whereas, Recently in Cleveland, Ohio, a physician was at an accident site administering care to an injured person preceding the arrival of Emergency Medical Services personnel; and
Whereas, Upon arrival of the Emergency Medical Services personnel, the

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Minutes of the Second Session (continued)

physician was directed to leave the site; and

Whereas, The physician was summarily dismissed from the site by police; and
Whereas, These incidents illustrate the needs for the establishment of a protocol which specifies the manner in which Emergency Medical Services personnel shall respond at the scene of an emergency where a physician is present and examining and/or rendering care to a patient(s); therefore be it

RESOLVED, that the House of Delegates of the Ohio State Medical Association instruct the Council of Ohio State Medical Association to establish a protocol for Emergency Medical Services personnel who respond to the scene of an emergency where a physician is already administering care to the patient(s); and be it further
RESOLVED, THAT COUNCIL SHALL REPORT ITS PROGRESS AT THE NEXT ANNUAL MEETING OF THE HOUSE OF DELEGATES OF OSMA; AND BE IT FURTHER

RESOLVED, that the Ohio State Medical Association request the American Medical Association to establish a protocol for Emergency Medical Services personnel who respond to the scene of an emergency where a physician is present and examining and/or providing care to the patient(s).

THE REPORT OF RESOLUTIONS COMMITTEE NO. 2, AS A WHOLE, AS AMENDED, WAS APPROVED BY THE HOUSE.

REPORT OF RESOLUTIONS COMMITTEE NO. 3

Dr. Lee J. Vesper, Hamilton County, as chairman, presented the report of Resolutions Committee No. 3:

Mr. President and members of the House of Delegates. Resolutions Committee No. 3 met in open session on Saturday May 1, 1982 and heard testimony relating to Resolutions 26-82 through 38-82, Resolution 40-82, and the President's Address.

RESOLUTION 26-82 RECOGNITION OF THE OHIO CANCER INFORMATION SERVICE

The Committee in its deliberations felt that at this time of budgetary restraints at the national, state and local levels, efforts to secure federal financial support for this program are inappropriate.

The concept of OCIS has been endorsed by the OSMA Council. Continuation of OCIS is encouraged if private funding can be obtained.

Several regional systems already in effect could probably handle the work of the OCIS if OCIS funding is not available. This would eliminate the duplication of services and increase the degree of local awareness but still provide statewide availability of this information.

Information regarding these regional centers, including telephone numbers, can be disseminated through the offices of the OSMA.

The Committee offers the following Amended Resolution:

AMENDED RESOLUTION NO. 26-82 RECOGNITION OF THE OHIO CANCER INFORMATION SERVICE

Whereas, The Ohio Cancer Information Service (OCIS) has provided a toll-free informational service for more than 12,000 Ohio health professionals, cancer patients, and the lay public in the past two and one-half years; and
Whereas, The Ohio Cancer Information Service (OCIS) provides accurate up-to-date information concerning prevention, symptoms, detection, treatment, rehabilitation, and terminal care issues caused by cancer; and

Whereas, The National Cancer Institute, The American Cancer Society, and the Ohio State University Comprehensive Cancer Center utilize the OCIS as an informational bridge to the public; and
Whereas, the Ohio State Medical Association and the OCIS share the common goals of reducing people's fears of cancer, dispelling cancer myths, and stressing early detection; therefore be it

RESOLVED, That the Ohio State Medical Association and the OSMA Medical Student Section recognize the importance of cancer information services statewide and of continuing to make this type of service available to all the citizens of Ohio. Mr. President, I so move.

By official action, the House voted to adopt Amended Resolution No. 26-82.

RESOLUTION 31-82 Strengthening the Penalties for Drunk Driving in the State of Ohio

RESOLUTION 32-82 Drunk Driving Laws

RESOLUTION 34-82 To Eliminate the Consequences of Driving While Under the Influence of Alcohol and/or Illegal Drugs

The Committee heard testimony on these resolutions and offers the following substitute resolution:

SUBSTITUTE RESOLUTION 31-82 STRENGTHENING OF OHIO'S DRUNK DRIVING LAWS

Whereas, Ohio Senate Bill 432, the Omnibus Drunk Driving Bill sponsored by Senator Michael DeWine (R-Cedarville), passed by 30-0 vote on Thursday April 29, 1982, THEREFORE BE IT

RESOLVED, That OSMA support the concepts contained in Senate Bill 432; and BE IT FURTHER

RESOLVED, That the OSMA through its various departments offer its services to the Ohio Departments of Health, Education and Transportation to pursue vigorously the education of adults and children as to the consequences of alcohol abuse and the law. Mr. President, I so move.

By official action, the House voted to adopt Substitute Resolution No. 31-82.

RESOLUTION 33-82 Physicians Health Insurance Company (PICO)

The Committee heard testimony on this resolution and offers the following amended resolution:

AMENDED RESOLUTION 33-82 PHYSICIANS HEALTH INSURANCE COMPANY (PICO)

Whereas, PICO publishes frequent periodic reports, such as PICO Pulse, as well as the annual report, which are distributed to all OSMA members; and

Whereas, PICO holds an annual stockholders meeting during the OSMA Annual Meeting, THEREFORE BE IT

RESOLVED, That the annual oral report of PICO by the chairman of its board be eliminated from the agenda of this OSMA House of Delegates; and BE IT FURTHER

RESOLVED, That PICO be encouraged to continue update seminars at the OSMA Annual Meeting. Mr. President, I so move.

By official action, the House voted to reject Amended Resolution No. 33-82.

RESOLUTION 35-82 Education Regarding Suicide Recognition, Prevention and Treatment

The Committee heard testimony regarding this resolution and recommends an amended resolution as follows:

AMENDED RESOLUTION 35-82 EDUCATION REGARDING SUICIDE RECOGNITION, PREVENTION AND TREATMENT

Whereas, The American Medical Association recognizes that a physician's duty and responsibility is to recognize, diagnose, and treat illness and disease in all forms; and

Whereas, There has been an increase in suicidal attempts and successes all over the world in the past 20 years — tripling among young males and doubling among young females; and
Whereas, physician skills in recognizing persons at risk for suicide and managing suicidal patients generally need to be improved; and

Whereas, suicide may frequently be preventable; THEREFORE BE IT
RESOLVED, That the House of Delegates of the OSMA encourage physicians to continue their education in suicide recognition, treatment, and prevention OF POTENTIAL SUICIDE VICTIMS — and also the management of survivors of suicide attempts/ and BE IT FURTHER.

~~RESOLVED, That the OSMA delegation to the AMA introduce this same resolution at the 1982 Annual Meeting of the AMA House of Delegates. Mr. President, I so move.~~

By official action, the House voted to amend Amended Resolution No. 35-82 and adopted it. The additions are indicated by capital letters and the deletions by strike-outs.

RESOLUTION 37-82 Medical Implications of a Mass Evacuation

The Committee felt that the position of the AMA House of Delegates, as expressed in the Board of Trustees Report DD

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approved in December 1981 established a responsible position for the physicians of Ohio and the nation. We therefore do not feel Resolution 37-82 is necessary and recommend that it be *REJECTED*.

For your information, the following are the recommendations of report DD:

1. Inform the President and the Congress of the medical consequences of nuclear war so that policy decisions can be made with adequate factual information.

2. Prepare appropriate informational materials to educate the physician population and the public on the medical consequences of nuclear war.

3. And other health care organizations cooperate (sic) with the responsible authorities in dealing with those matters having to do with health and medical care in the event of national emergencies, including those associated with military hostility.

4. Not become involved in political issues outside its professional expertise such as national defense and the politics of nuclear war preparedness inasmuch as it is not appropriate for the AMA to do so.

By official action, *the House voted not to reject Resolution 37-82. A substitute resolution was submitted and the House voted to adopt it.* Substitute Resolution No. 37-82 reads as follows:

RESOLVED, THE OSMA HOUSE OF DELEGATES REAFFIRMS THE POSITION OF THE AMA HOUSE OF DELEGATES AS EXPRESSED IN THE BOARD OF TRUSTEES REPORT DD APPROVED IN DECEMBER 1981 AND URGES ALL MEMBERS TO BECOME FAMILIAR WITH ITS FOUR RECOMMENDATIONS.

RESOLUTION 38-82 Public Relations

The Committee received testimony that the OSMA, through its Department of Communications, conducted several regional communications seminars in 1978 and 1979. They were sparsely attended. Considering the expense involved, they were discontinued and during the past two years they were replaced with a series of Focus Group Interviews. These interviews have been held throughout the state with various groups of physicians. These interviews determine areas of major concern to OSMA members.

During the past year, the Communications Department has spent a great deal of time traveling around the state meeting with county medical societies to assist in the development of local communications programs. The Department offered to conduct public relations seminars, media and speaker's training seminars to any county society upon request and has publicized the availability of these services through the OSMAgram and the Journal. During the Fall Leadership Conference, the Department will conduct a day long speakers/media training seminar for physicians.

The Committee feels that the intent of Resolution 38-82 is already being served and recommends that it be *REJECTED*.

By official action, *the House voted to reject Resolution No. 38-82.*

RESOLUTION 40-82 Ohio State Medical Hall of Fame

The Committee heard much favorable testimony on the need to preserve in a concrete way our rich heritage of Ohio medicine and honor those men and women of vision and action who have preceded us.

There was testimony regarding solicitation of outside monies through a nonprofit foundation to create and support a Medical Hall of Fame.

Since the basis for acceptance as an emergency resolution was the fact that an addition to the OSMA headquarters would be designed in the next year, the Committee was very concerned that considerable expense for architectural planning would be incurred during the pursuit of this feasibility study, only to find this project not feasible.

The Committee recommends that those interested in this worthy project develop more specific ideas regarding the nature and scope of the Medical Hall of Fame, explore possible sources of funding, and return at a later date with more specific recommendations. Therefore, the Committee recommends that Resolution 40-82 be *REJECTED*.

By official action, *the House voted to refer Resolution No. 40-82 to the Council.* The resolution reads as follows:

WHEREAS, Our civilization and our profession is built on the cumulative contributions of our predecessors; and,

WHEREAS, In Ohio we have great leaders past, and present, and no responsible person can fail to acknowledge our enormous debt to them; and,

WHEREAS, Larger facilities are planned for the Ohio State Medical Association in the near future; and,

WHEREAS, The Art and Culture Committee has approved the concept and foresees a future participatory role; and,

WHEREAS, Funding considerations include possible contributions from Foundations interested in history; therefore,

BE IT RESOLVED, That the Ohio State Medical Association President appoint a committee to study the feasibility of an Ohio State Medical Hall of Fame, to include space requirements, financial projections, related experiences of other state medical associations, and guidelines for candidates.

REPORT ON THE PRESIDENT'S ADDRESS

Dr. Dunsker emphasized that his goal as president was to establish a continuity of progressive programs in 10 major areas. He discussed numerous accomplishments within these areas highlighted by membership development, creation of a group professional liability program by PICO, programs for increasing nondues revenue, development of PACO to provide a wide range of administrative services including direct entry billing for Medicaid claims, increased communications to the membership, and close cooperation with the OSMA Auxiliary within the OSMA Council and its committees.

In looking to the future, Dr. Dunsker

cited the nation's economic problems and the increasing demands for physician services and rapidly emerging competition. He warned that the professional liability problem will continue as long as government plays a significant role in paying for health care, and that increasing numbers of nonphysician health care providers are entering the scene.

He concluded that organized medicine must put its squabbles aside in order to be more effective in the legislative and government relations arenas.

We commend Dr. Dunsker for the thoughtful and untiring leadership and guidance he has provided through this year of his stewardship of our organization. With him we strain to see what the future holds for medicine, but supported on the strong proactive foundation he has laid for us and forewarned of the problems and pitfalls likely to be encountered, we can move our OSMA forward with confidence as the gavel of leadership is passed from one strong hand to another.

By official action, *the House voted to file the report.*

RESOLUTION 27-82 To Develop Within the MSS Programs Which Would Assist in Improving the Public Health

The Committee placed Resolution No. 27-82 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, The purpose of the Ohio State Medical Association is to provide programs to improve service to the public in matters of personal and public health; and

Whereas, The Medical Student Section has as one of its objectives to support the purposes of the Ohio State Medical Association; therefore be it

RESOLVED, That the Medical Student Section participate in public service activities of the Ohio State Medical Association, where its presence is requested by the OSMA; and be it further

RESOLVED, That the Medical Student Section strive to establish programs whereby its members can assist the public through service activities.

By consent, *the House adopted Resolution No. 27-82.*

RESOLUTION 28-82 To Establish and Announce MSS Involvement in Community Public Health Affairs Projects

The Committee placed Resolution No. 28-82 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, The Medical Student Section has proposed establishing public service activities; therefore be it

RESOLVED, That the Medical Student Section be available as a clearinghouse and coordinator for communities and public health organizations requesting medical students to participate in programs which will seek to improve the public health; and be it further

RESOLVED, That the Ohio State Medical

Association and the Medical Student Section, in their communications with the public and with public health organizations, announce this function of the Medical Student Section.

By consent the House adopted Resolution No. 28-82.

RESOLUTION 29-82

To Establish and Announce a Program Which Would Supply Medical Students as Speakers at Civic and Career-Orientation Programs

The Committee placed Resolution No. 29-82 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, The Medical Student Section represents medical students from all medical schools in Ohio; and

Whereas, Many high schools and colleges in Ohio have no affiliation with a medical school; therefore be it

RESOLVED, That the Medical Student Section acts as a clearinghouse and coordinator for high schools, colleges, and civic groups requesting medical students to act as speakers; and be it further

RESOLVED, That the Ohio State Medical Association and the Medical Student Section, in their communications with such groups, announce this function of the Medical Student Section.

By consent the House adopted Resolution No. 29-82.

RESOLUTION 30-82

To Establish a Program Which Would Match Medical Students with Externship and Elective Rotations Available in Ohio

The Committee placed Resolution No. 30-82 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, The Medical Student Section seeks to further the academic experiences of its student members; and

Whereas, The services of a medical student would be valuable to physicians, public health organizations, and medical clinics not affiliated with a medical school; therefore be it

RESOLVED, That the Medical Student Section acts as a clearinghouse and coordinator for physicians and public health organizations requesting the services of 3rd or 4th year medical students performing an elective rotation; and be it further

RESOLVED, That the Medical Student Section disseminates information about this function to the OSMA and its member physicians, county medical societies, and public health organizations.

By consent the House adopted Resolution No. 30-82.

RESOLUTION 36-82

Nuclear Waste Storage Under Lake Erie

The Committee placed Resolution No. 36-82 on the Consent Calendar and recommended its adoption. The resolution reads as follows:

Whereas, Studies are currently being proposed to determine if nuclear waste

will be stored in the salt caverns beneath Lake Erie; and

Whereas, Lake Erie and the other Great Lakes comprise the largest collection of fresh water in the world; and

Whereas, Clean, fresh water is an absolute essential for the life and health of the human race, and all other living things; and

Whereas, Thirty million people in Ohio and other areas of the United States and Canada depend on this water for their life and health; and

Whereas, Any catastrophe involving stored nuclear waste beneath Lake Erie could result in contamination of fresh water and untold consequences to the public health of the people who depend upon this fresh water for their very existence; therefore be it

RESOLVED, That the Ohio State Medical Association express, to the Federal Department of Energy and Ohio Department of Natural Resources, its concern with the possible use of salina salt beds for the storage of nuclear waste; and be it further

RESOLVED, That the Ohio State Medical Association urge the American Medical Association, through the AMA Council on Scientific Affairs to study the problems involved in the storage of nuclear waste and recommend to the Federal Department of Energy the safest and most effective way to store nuclear waste.

By consent the House adopted Resolution No. 36-82.

Mr. President, this concludes the Report of Resolutions Committee No. 3.

THE REPORT OF RESOLUTIONS COMMITTEE NO. 3, AS A WHOLE, AS AMENDED, WAS APPROVED BY THE HOUSE.

UNFINISHED BUSINESS

Dr. Dunsker commended the staff for the organization of the meeting. The House concurred. This was acknowledged by the Executive Director on behalf of the staff.

Dr. Dunsker also commended the Montgomery County Medical Society for its hospitality during the meeting. The House concurred. Dr. Abromowitz responded on behalf of the Montgomery County Medical Society.

INAUGURAL CEREMONY

Dr. Dunsker introduced Dr. Robert G. Thomas, Immediate Past President.

Dr. W. "Jack" Lewis, Dayton, escorted Mrs. Ford and the Ford family to the podium to join Dr. Ford.

Dr. Thomas administered the Presidential Oath of Office to Dr. Ford.

Dr. Ford then introduced his family to the House and addressed the House.

Dr. Dunsker then presented to Dr. Ford the official gavel and the President's Medallion.

Dr. John E. Albers, Cincinnati, escorted Mrs. Dunsker to the podium.

Dr. Ford presented to Dr. Dunsker, the past president's pin, the president's plaque, replica of president's medallion to Mrs. Dunsker and replica of president's medallion to Dr. Dunsker.

There being no further business, the House of Delegates then adjourned, sine die.

ATTEST: Hart F. Page, CAE
Executive Director
and
Carol C. Maddy
Assistant Secretary
House of Delegates

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OSMA's new president-elect

The Ohio State Medical Association (OSMA) is proud to welcome S. Baird Pfahl, Jr., M.D., as the Association's new president-elect.

Dr. Pfahl, an ophthalmologist from Sandusky, Ohio, has been very active in the OSMA, the AMA, and in numerous ophthalmologic associations for many years.

Following his undergraduate training at Harvard University, from which he received his B.A. degree in 1955, Dr. Pfahl took his medical education from the University of Pittsburgh. Upon receiving his medical degree in 1959, he interned at Western Pennsylvania Hospital, took a residency in ophthalmology at Ohio State University, then served two years at the United States Naval Hospital in Memphis, Tennessee. After his discharge from the Navy, Dr. Pfahl established his present practice in Sandusky.

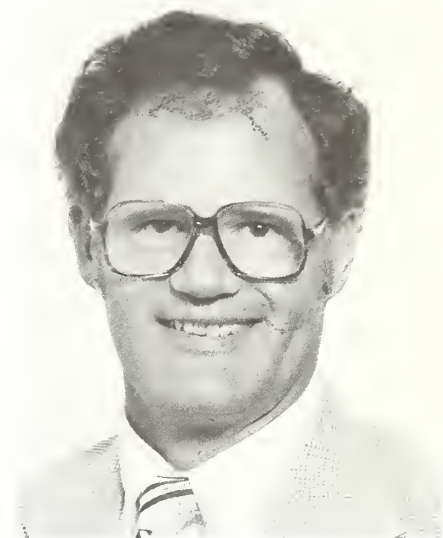
An active member of professional organizations, Dr. Pfahl has served as Eleventh District Councilor to the OSMA since 1976, and has served as Chairman of the OSMA's Committee

on Cost Effectiveness; the Ad Hoc Auxiliary Liaison Committee; and the Auditing and Appropriations Committee. He has also been active in his county medical society and is a member of the American Medical Association.

Dr. Pfahl also is involved in a number of specialty associations. He is a past president of both the Ohio Ophthalmology Society and the Ophthalmology Society of Northwest Ohio; is a diplomate of the American Board of Ophthalmology; and a Fellow of the American Academy of Ophthalmology. He also maintains an active membership in the Society for Contemporary Ophthalmology, the American Intraocular Implant Society and the Contact Lens Association of Ophthalmologists. Along other professional lines, Dr. Pfahl is a team physician for Huron City Schools, and has recently received an appointment to the Medical College of Ohio, where he serves as Clinical Assistant Professor in the Department of Surgery.

Outside his profession, Dr. Pfahl is

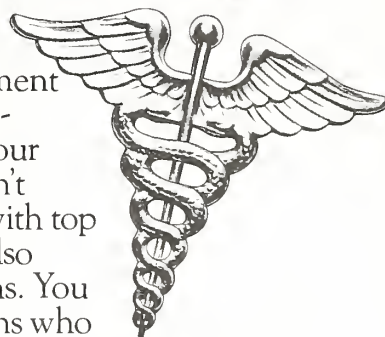
an active member in the Rotary Club of Sandusky, having served a year as the group's President. Married to the former Phyllis Bolman, the Pfahls have four sons, Scott, Doug, Dan and Todd.



*S. Baird Pfahl, Jr., M.D.,
Sandusky,*

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References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease*, op. cit., p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, op. cit., pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med* 89 (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.



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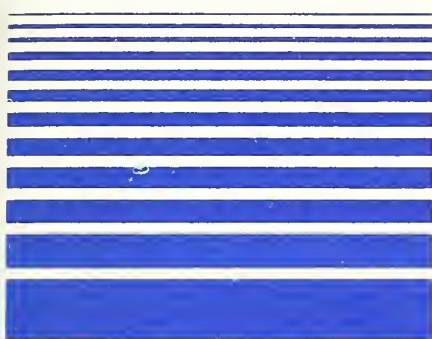
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Obituaries



ADRIAN E. DAVIS, M.D., Akron; Jefferson Medical College, 1926; age 82; died April 23, 1982; member OSMA and AMA.

THOMAS J. HERBERT, M.D., Portsmouth; Medical University of South Carolina College of Medicine, Charleston, South Carolina, 1926; age 80; died April 26, 1982; member OSMA and AMA.

RAYMOND B. HUDSON, M.D., Columbus; Eclectic Medical College, Cincinnati, 1927; age 81; died May 11, 1982; member OSMA and AMA.

HUSSEIN ISMAIL, M.D., Batavia, New York; Abbasis Faculty Medical University of Ein Shams, Cairo, Egypt,

1964; age 42; died April 14, 1982; member OSMA.

WILLIAM H. JACOBSON, M.D., Palm Springs, California; Washington University School of Medicine, Columbia, 1936; age 71; died March 19, 1982; member OSMA and AMA.

SEYMOUR KYMAN, M.D., Cleveland; Case Western Reserve University School of Medicine, Cleveland, 1931; age 75; died May 7, 1982; member OSMA and AMA.

JEROME J. MAGGIORE, M.D., Canton; Loyola University Stritch School of Medicine, Maywood, 1938; age 69; died April 10, 1982; member OSMA and AMA.

STANLEY J. MATT, M.D., Chagrin Falls; Loyola University Stritch School of Medicine, 1941; age 69; died May 6, 1982; member OSMA and AMA.

LESLIE E. NEEDHAM, M.D., Verdes, California; Indiana University School of Medicine, Indianapolis, 1926; age 82; died April 8, 1982; member OSMA.

MICHAEL T. PALEN, M.D., Canton; State University of New York at Buffalo School of Medicine, 1935; age 76; died May 5, 1982; member OSMA and AMA.

CHARLES O. PARADIS, M.D.,

Canton; McGill University Faculty of Medicine, Toronto, 1921; age 87; died April 24, 1982; member OSMA and AMA.

HUGO ROSENTHAL, M.D., Hollywood, Florida; Germany, 1924; age 82; died April 4, 1982; member OSMA.

THEODORE SELKIRK, M.D., Cincinnati; Harvard Medical School, Boston, 1923; age 85; died April 14, 1982; member OSMA and AMA.

JOHN H. SPILLANE, M.D., San Diego, California; University of Colorado School of Medicine, Denver, 1934; age 71; died February 10, 1982; member OSMA and AMA.

JOHN R. SYLVESTER, M.D., Cleveland; Temple University School of Medicine, Philadelphia, Pennsylvania, 1956; age 51; died April 18, 1982; member OSMA and AMA.

JACOB WACKER, M.D., Columbus; University of Munchen Bayern, Munich, Germany, 1924; age 81; died April 8, 1982; member OSMA and AMA.

JERRY S. WOLKOFF, M.D., Cleveland; Case Western Reserve University School of Medicine, Cleveland, 1954; age 54; died April 27, 1982; member OSMA.

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EAR DISEASE 1982: September 10-11; Stouffer's Cincinnati Towers; 14 credit hours; sponsor: Bethesda Hospital, Cincinnati; fee: \$145; contact: Thomas O'Connor, Bethesda Hospital, 619 Oak Street, Cincinnati 45206, phone: 513/559-6337.

September

PULMONARY DISEASE UPDATE — 1982: September 15-16; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; 12 credit hours; fee: \$140, \$65 for physicians-in-training; contact: Director of CME,

Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696.

TRAUMA MANAGEMENT UPDATE — 1982: September 22; Holiday Inn, Dayton Mall, I-75 at Rt. 725; 7 credit hours; fee: \$70 Wright State Faculty, \$90 for others; contact: Mary B. Fisher, Wright State University School of Medicine, Box 927, Dayton 45401, phone: 513/372-7140.

SECOND UPDATE AND REFRESHER IN PSYCHIATRY: September 24-25; Stouffer's Dayton Plaza Hotel; 13 credit hours; sponsor: Wright State University School of Medicine; fee: \$125 Wright State Faculty, \$150 others; contact: Mary B. Fisher, Wright State University School of Medicine, Box 927, Dayton 45401, phone: 513/372-7140.

NEW MEMBERS

ALLEN

Michael Dale Holmes, Cleveland
Michael W. Kim, Lima
Mark A. Winerman, Lima

BELMONT

Mario C. Mejia, Martins Ferry

BUTLER

Clyde D. Brown, Wyoming
Bradley T. Martin, Kettering
Robert V. Reinhold, Fairfield

CLARK

Jerald Lee Brinley, Springfield

CUYAHOGA (Cleveland unless noted)

Robert J. Cunningham
William R. Hart
Robert A. Ratcheson
Mark A. Roth

George H. Thompson
Nandigam Veerendra
David M. Waggoner
David M. Weiner

DELAWARE

John A. Rosenfield, Delaware

FRANKLIN

Steve Bushek, Canal Winchester

HAMILTON (Cincinnati unless noted)

Prasad G. Chandra, Cleves
Sang Youl Choi
Jim K. Goodrum
Charles L. Heaton
Peter G. Ruehlman

LICKING

L.G. Ratcliff, Newark

LUCAS (Toledo unless noted)

Michael L. Gross
Garth D. Phibbs
Robert A. Schmidt, Rossford
Robert E. Shanahan

MAHONING

Joseph A. Colella, Youngstown
Joseph P. Myers, Youngstown

MONTGOMERY

Lucille C. Gunning, Dayton
Charles Shoham, Dayton

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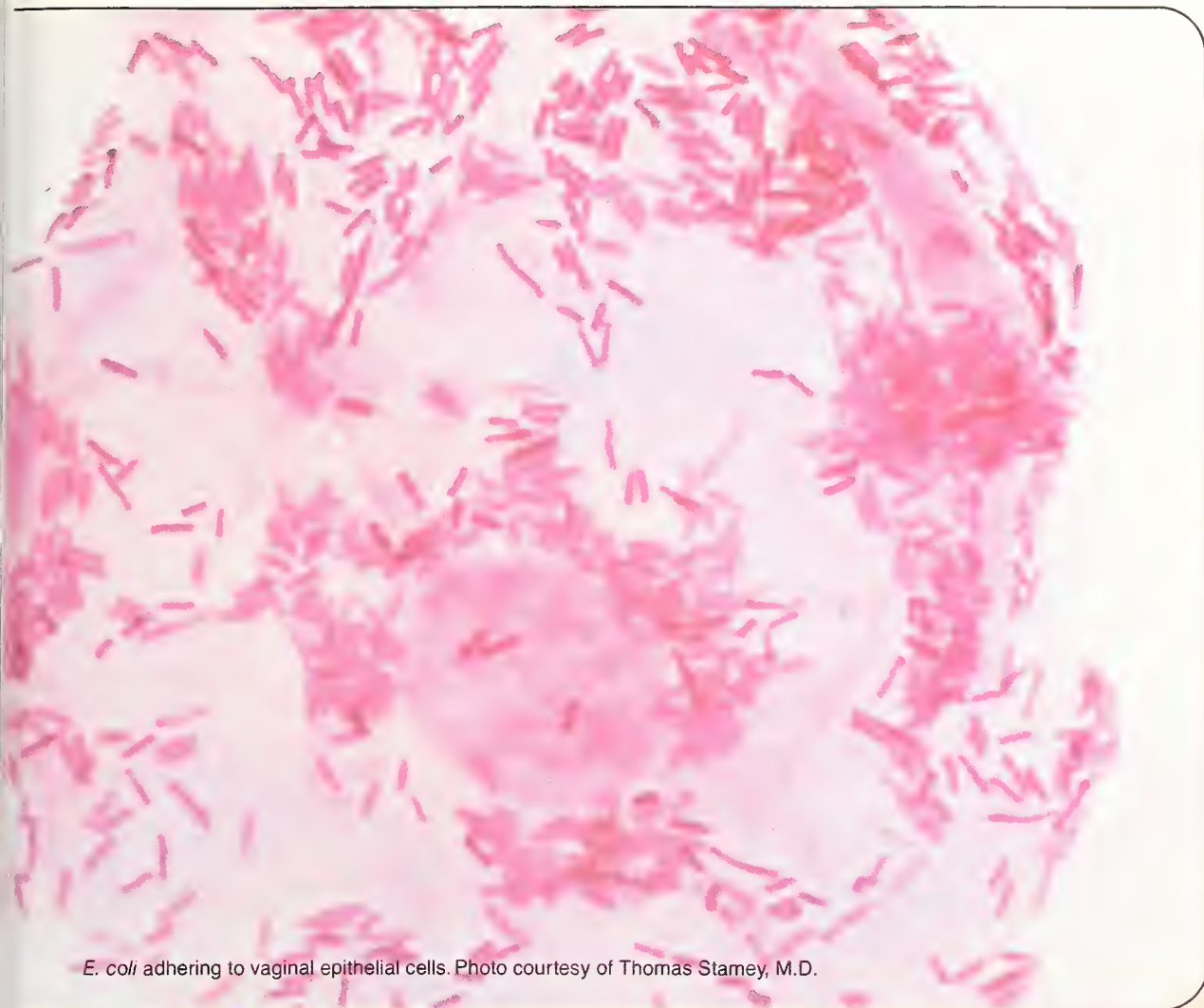
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cling to receptors



E. coli adhering to vaginal epithelial cells. Photo courtesy of Thomas Stamey, M.D.

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See next page for references and a summary of product information.

References: 1. Källénius G et al: *Lancet* 2:604-606, Sep 19, 1981. 2. Lomberg H et al: *Lancet* 1:551-552, Mar 7, 1981. 3. Schaeffer AJ et al: *N Engl J Med* 304:1062-1066, Apr 30, 1981. 4. BacData Medical Information Systems: *Antibiotic Sensitivity Report*, Winter Series, 1981. 5. Stamey TA, Condy M: *J Infect Dis* 131:261-266, Mar 1975. 6. Rubin RH, Swartz MN: *N Engl J Med* 303:426-431, Aug 21, 1980.

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For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

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Also for the treatment of documented *Pneumocystis carinii* pneumonia.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

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PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. **Blood dyscrasias:** Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. **Allergic reactions:** Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. **Gastrointestinal reactions:** Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea, pseudomembranous colitis and pancreatitis. **CNS reactions:** Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. **Miscellaneous reactions:** Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

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Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

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Address All Correspondence, Address Change, & Reprint Request (unless otherwise noted): Executive Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215. Phone: 614/228-6971.

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1981 Subscription: \$15 per year, single copy \$2 (outside U.S. \$20 and \$3).

Send address changes to: The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second Class Postage paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by

The Lawhead Press, Inc., Athens, Ohio



ROCHE LABORATORIES
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SECOND OPINION

Pigeons Are Gray . . . and Other Important Facts

By Brooks A. Mick, M.D.

Most people go through life busily stuffing pigeons into pigeonholes. For example, some politicians say that the unemployed simply are not looking for work because of laziness or ignorance of opportunity. Others say they are laid off from jobs, disabled, or otherwise not at fault. The truth, as usual, may lie somewhere in between.

Let us say, for example, a generally healthy, hard-working young man injures his back, is off work for 40 days following back surgery, watches TV, goes fishing, plays with the kids, and gets lots of love, affection, and sympathy. When it comes time for him to return to work, he quite often goes to his doctor and says, "My back is still bothering me — I need more time off." Unfortunately, at this point, the doctor often goes along with this, even though he can find no objective reason why the man cannot return to work immediately.

Which leads me to my second point. People learn, often subconsciously, several things during an illness. "They

learn that they get a lot of attention and affection while sick." They learn they can get paid for staying home and they can get paid for having back pain. They learn that often it is much more enjoyable to stay home than it is to go to work in a stressful, difficult, or just plain boring job. And they can learn to have pain if it is in their

Many times the original cause of a pain may be gone, yet the pain stays if there is sufficient benefit gained from it.

interest to do so. Many times the original cause of a pain may be long gone, yet the pain stays if there is sufficient benefit gained from it. This

is somewhat like the pain people may feel in a foot after the leg has been amputated. It is the brain, not the phantom foot, which feels pain. And it can feel pain even when nothing outside the brain is causing it.

Now, into which pigeonhole do we place this unfortunate young worker? If we continue to pay his Workers' Compensation or disability payments, permitting him to stay home instead of working to support his family, are we not further teaching him to have pain in order to get money? If we disallow his payments because we find no objective evidence of illness, what is he going to do, since he still feels pain and he truly believes he is not healed yet? Quite a dilemma, isn't it?

What needs to be done, I believe, is to find out how we can prevent such a chain of events from occurring. Once it has occurred, we need the courage to take an appropriate stand. My suggestions are as follows:

1. We must encourage physicians to limit the time allowed off for illness to

under 40 days, if at all possible. Studies show that, after 40 days off, return to work becomes increasingly improbable, even if the original illness is cured.

2. Physicians must steel themselves against the understandable impulse to extend a sick leave — if no objective evidence for continued disability exists.

3. Social workers must be taught that their goal should be the return of the worker to his job. It does not help a man to pay him for pain — it merely prolongs, perhaps for life, his pain and his dependence upon society.

4. Politicians must stop to think of the consequences of their understandable efforts to alleviate hardships. Often, the ultimate consequence is that their laws teach a dependence upon government and teach that continued comfort and money depend on continued pain.

One could think it cruel, perhaps, that the mother bird pushes her young out of the nest, but she is really helping them to get on with their lives and to be self-reliant. The same might

be thought of the denial of disability payments, unless objectively warranted. This denial, far from being "cruel," may be a necessary encouragement to a return to productive life. No one — doctor, social worker, politician — is going to be right all the time. But it is highly unlikely, in the absence of hard evidence for illness, that anyone would be harmed by a return to work. It is evident, however, that continued disability payments often result in continued pain.

The treatment of chronic pain syndrome is beyond the scope of this article, but several simple points have been demonstrated. It is best to avoid treatment with narcotics and tranquilizers — and often it is best to ignore the pain behavior of the patient. Since they are often victims of endogenous depression they would not likely be disabled if they received adequate antidepressant therapy.

This article also ignores those who are deliberately malingering. As in real life, these pigeons are rare. We should remember, if we wish to help chronic

pain syndrome sufferers and to help our government and our economy, that pigeons are gray and that people are learning machines. And we must be very careful what we teach them. . .

Brooks A. Mick, M.D., a member of the OSMA, practices internal medicine in Findlay, Ohio.

"Second Opinion" is a column of opinion, written by OSMA members and discussing important issues facing medicine today. The articles express the personal opinions of the authors and do not necessarily reflect official OSMA or JOURNAL policy. The JOURNAL encourages individual members to submit articles for this column. Preference will be given to short, concise articles which discuss the current issues of the day.

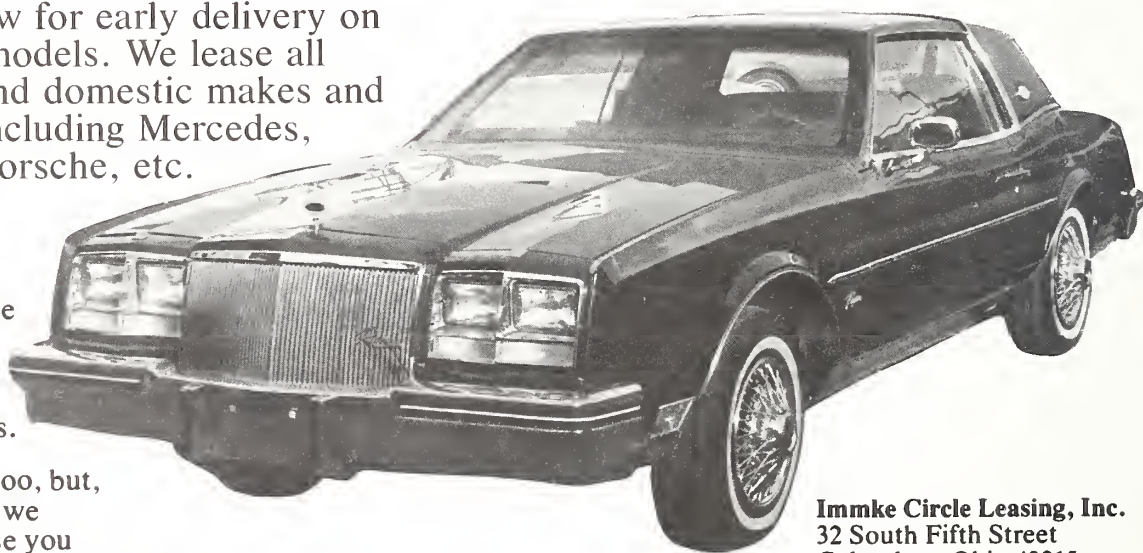
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DUDLEY F. BRIGGS, M.D., Columbus, was selected Physician of the Year for 1981 by the President's Committee on Employment of the Handicapped. Dr. Briggs is medical director of Western Electric's Columbus Works where he helped establish a joint labor-management committee to identify jobs that can be performed by temporarily and permanently disabled employees. Dr. Briggs is also a clinical assistant professor at Ohio State University and has written numerous articles for medical magazines.

WALTER A. HOYT, M.D., Akron, was named 1981 "Surgeon of the Year" by the National Safety Council, the American College of Surgeons, and the American Association for Surgery Trauma. Dr. Hoyt was honored for his distinguished service to the cause of safety.

JOSEPH E. LEVINSON, M.D., Cincinnati, was named Greater Cincinnati's Medical Researcher of the Year. Dr. Levinson is professor of medicine and pediatrics at University of Cincinnati Medical School, and director of the Special Treatment Center for Juvenile Arthritis.

FRANK S. McCULLOUGH, M.D., associate professor, department of medicine, and chief of the division of gastroenterology, was installed as chief

continued on page 524

Gifford, Albers elected to AMA Council posts.

The Ohio State Medical Journal extends its congratulations to two OSMA members: **RAY GIFFORD, JR., M.D.,** and **JOHN E. ALBERS, M.D.,** who were recently elected to AMA Council posts at the AMA's annual meeting held recently in Chicago.

Ray Gifford, Jr., M.D. — Council on Scientific Affairs

Dr. Gifford was reelected to the AMA's Council on Scientific Affairs, a position he has occupied for the past six years.

From Cleveland, Dr. Gifford is the Chairman of the Department of Hypertension and Nephrology and Vice-Chairman of Medicine at The Cleveland Clinic Foundation.

He has been very active in scientific affairs and has served in numerous organizations including the American Society for Clinical Pharmacology and Therapeutics; as an AMA representative on the National Council on Drugs, and as Chairman of the Study Group on Hypertension for the Inter-Society Commission on Heart Disease resources.

Dr. Gifford also has worked in various capacities on behalf of organized medicine. He is a past delegate to the AMA; President of the Academy of Medicine of Cleveland; a Delegate to the OSMA; and an AMA alternate delegate.

In addition, he has the distinction of having authored and coauthored over 330 scientific publications and is a Fellow of the American College of Physicians; a Fellow of the American College of Cardiology and a Fellow of the American College of Chest Physicians.

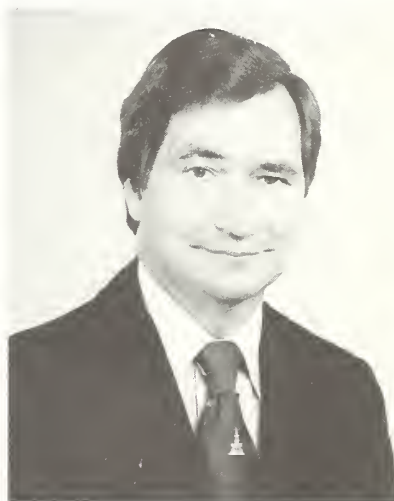
John E. Albers, M.D. — Council on Medical Education

Dr. Albers was recently elected to the AMA's Council on Medical Education. As a strong believer in maintaining high standards of medical education, he has worked hard to promote his belief on a personal, local, state and even national level.

In addition to his private practice of cardiac, thoracic and vascular surgery



Ray Gifford, Jr., M.D., Cleveland.



John E. Albers, M.D., Cincinnati.

in Cincinnati, Dr. Albers has been active in numerous organizations. He is a past president of the Academy of Medicine of Cincinnati, a delegate to both the AMA and OSMA and a member of the Primary Care Medicine Advisory Committee, Ohio Board of Regents.

He also has served as a medical educator and administrator in various capacities. He is a past chairman of both the AMA and OSMA Council on Continuing Physician Education, and Head, Cardiovascular Section, Thoracic Residency Training Program, Good Samaritan Hospital, Cincinnati.



a compilation of the latest developments, reports and products of interest to physicians.

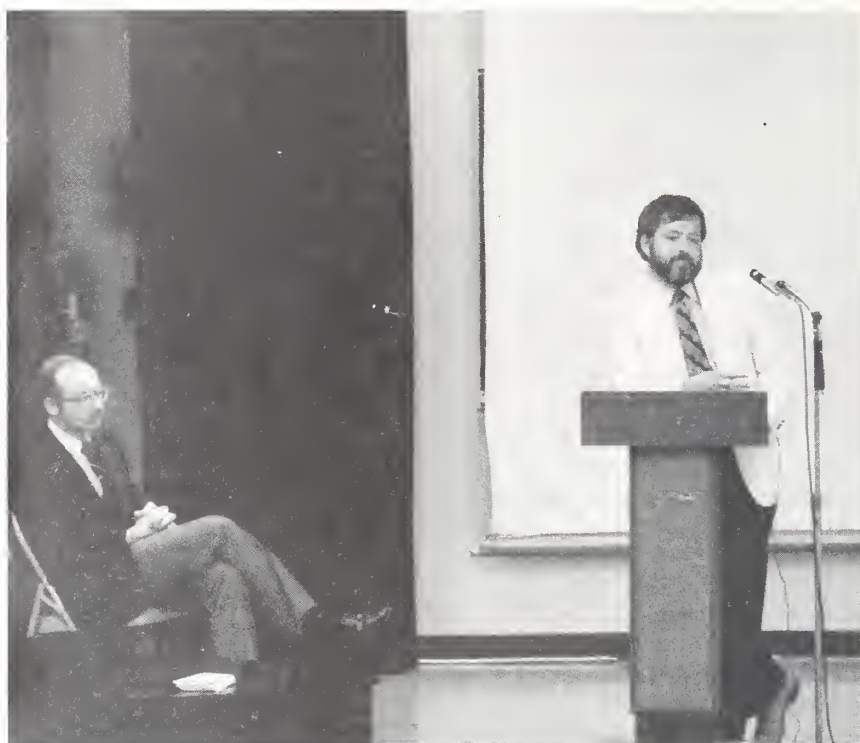
**edited by
Gina DiBlasio Cummins**

Prudent use of ultrasound advised

In the past ten years, ultrasound has developed from a research instrument into a valuable and widely used diagnostic tool, allowing obstetricians to "see" inside the womb. In a recent issue of the *Journal of the American Medical Association*, however, researchers and clinicians warn against routine use of ultrasound in prenatal care, citing their inability to quantify its risk.

The concern over the potential harmful effects of ultrasound is based on the results of animal and other laboratory studies in which abnormalities have been produced. These abnormalities, however, cannot yet be extrapolated to humans.

Because it is now possible with ultrasound technology to perform a physical exam of the fetus in the womb, the question in many obstetricians' minds is whether all pregnant women should be screened with diagnostic ultrasound. But since scientists are still grappling with ultrasound's unknowns, obstetricians should respond prudently, according to the articles' authors.



Moderator Leonard J. Janchar, M.D. (left) listens to one of the forum's featured speakers, Edward L. Charnock, M.D.

Marion Academy's health forum deemed a service to the community

The Marion Academy of Medicine recently joined with the *Marion Star* and the Ohio State University Marion Campus to present a series of health forums as a public service to the community.

Two forums were presented — the first one dealt with breast cancer, emergency medicine and the thyroid gland and featured speakers James S. Hering, M.D.; Edward L. Charnock, M.D.; and T. Richard Chen, M.D. Leonard J. Janchar, M.D., President of the Marion Academy of Medicine, moderated the program, fielding questions from the audience. The second forum featured discussions on childhood allergies, causes and treatment of cancer, and a more detailed discussion on sun and skin cancer. Albert N. May, M.D., Ronald A. Landefeld, M.D. and David W. Knox, M.D. served as speakers for the second forum.

Dr. Janchar said the events were planned as a means to educate the public and to help them understand their role in providing for their own health. "I don't think any doctor can take complete responsibility for the health of a patient," he said — and the message came through loud and clear at each forum — every patient is master of his/her own body.

The forums were well received and prompted one attendee — a school psychologist for the Marion City Board of Education — to write: "Your panel of physicians presented their information in such a way that we could easily understand their message. We were given a lot of new information; brought back to memory what we already knew; and reminded that we should always practice good health methods. . . Thank you for your concern for the people of our community."

MISCELLANEA

• New hope is on the horizon for asthma sufferers. The Upjohn Company reports that a new compound, U-60, 257, is scheduled to enter clinical trials for the prevention of asthma attacks. The compound selectively inhibits both the formation and actions of leukotrienes. Leukotrienes, it is believed, may play a crucial role in the elicitation of the symptoms of asthma.

• Examining the nightmare. . .The American College of Physicians (ACP) recently adopted a position paper on "The Medical Consequences of Radiation Accidents and Nuclear War." As ACP President, Thomas F. Frawley, M.D., puts it, "Both the public and the medical profession need to know more about the medical consequences of radiation accidents."

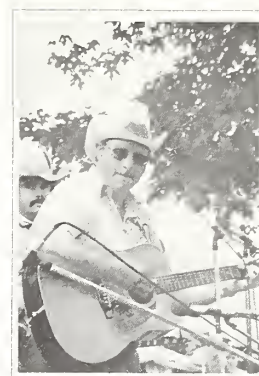
The ACP maintains that medical education must be improved to increase and update the information physicians receive about the medical consequences of radiation accidents. It also urges that medical care professionals be trained to triage and treat blast, radiation and burn injuries.

However, the College believes that there can be no adequate medical preparedness for the devastating medical consequences of nuclear war. "Prevention is the only reasonable medical response to the hazards posed by nuclear weapons," Dr. Frawley declared.

• Streptase (streptokinase), a medication in use since 1977 for treatment of deep vein thrombosis and pulmonary embolism, recently has been approved by the Food and Drug Administration for a new use. . .treating coronary artery thrombosis, a heart condition that accounts for approximately 90 percent of the heart attacks in the U.S. Jerome Weinstein, M.D., of Hoechst-Roussel Pharmaceuticals, Inc., the drug company that markets Streptase, said recently, "Doctors who studied the drug found that when injected into the coronary artery, Streptase quickly restores blood flow to limit damage to the heart in over 75 percent of cases with the blood clot usually dissolving in less than an hour."

profiles

A Little Bit Country



Dr. Ray has been recognized for his musical talents and his commitment to the medical profession. He is a member of the American College of Physicians and the American Medical Association. He has been a frequent speaker at medical conferences and has been published in several medical journals. He is also a member of the Ohio State Medical Association and the Ohio State Medical Journal.

Sports arena no longer a 'man's world,' as women and girls become more athletic

OSMA publications, staff receive awards and recognition

The awards may not be as widely recognized as those presented in the entertainment industry, but in the world of communications, the annual Peer Awards, presented by the International Association of Business Communications (IABC), are certainly no less prestigious.

The Ohio State Medical Association's Department of Communications managed to capture not just one but two of those awards. Assistant Editor, Gina Cummins, received an Award of Excellence for *Synergy*, OSMA's patient publication which was voted this year's "Best Newsletter/Magapaper." Carol Wright

Mullinax, the department's Associate Director, received an Award of Excellence for her story "A Little Bit Country," which profiled the country music interests of John Ray, M.D. (*The Ohio State Medical Journal*, September 1981). Ms. Mullinax's story won the "Best Feature Writing Award."

The Ohio State Medical Journal placed in the "Best Magazine" category, and OSMA member Ronald A. Naille, M.D., Columbus, an audio visual enthusiast, received recognition for his assistance on this year's "Best Audiovisual Program" winner. Congratulations to all.

Meetings

Diagnostic Ultrasound in Obstetrics and Gynecology. September 9-10. The Johns Hopkins Medical Institutions, Baltimore, Md. Interesting developments in the field of obstetrical and gynecological ultrasound will be reviewed, 16 credit hours, Category 1. For further information, contact: Program Coordinator, Office of Continuing Education, 720 Rutland Ave., Rm. 19, Turner Building, Baltimore, Maryland 21205.

Acute Renal Failure, 1982: A Symposium on Correlations between Morphology and Function. September 16-17, 1982. Johns Hopkins Medical Institution, Baltimore, Maryland. For information, contact: Program Coordinator, Office of Continuing Education, Room 22, Turner Auditorium Building, 720 Rutland Avenue, Baltimore, Md. 21205.

continued on page 556

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioğlu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric, *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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By Oscar W. Clarke, M.D. and C. Douglass Ford, M.D.

Editor's note:

This report covers some of the important issues voted on by the Ohio Delegation at the 1982 Annual Business meeting of the American Medical Association in Chicago, June 13-17, 1982.

There were 52 reports and 82 resolutions considered by the House of Delegates. Two of the resolutions were introduced by the Ohio Delegation.

Closed Caption Television

The first Ohio resolution, Closed Caption Television, was adopted by the AMA House of Delegates. This resolution asked that the American Medical Association commend the television networks for offering closed caption programming for the deaf and hearing impaired and encouraged continued expansion of such programming. The Federal Communications Commission and television stations also are to be made aware of the AMA position on this matter.

Support of the Civilian-Military Contingency Hospital System

A substitute resolution was adopted by the AMA House of Delegates in lieu of the Ohio resolution and a resolution on the same subject introduced by the Aerospace Medical Association. The substitute resolution is listed below:

"RESOLVED, That the American Medical Association support the

Civilian-Military Contingency Hospital System, and be it further

RESOLVED, That the American Medical Association urge United States civilian hospitals, when requested, to provide all possible support to the Department of Defense CMCHS in this important effort, which will enable the United States to prepare for the treatment of casualties from any future conventional military conflict."

The Ohio Delegation was in unanimous support of the adoption of the substitute resolution.

Second Surgical Opinion Programs: Status Report

The American Medical Association House of Delegates filed the informational report from the Council on Medical Service on second surgical opinion programs under government and private sector auspices which concludes that definitive evidence as to the effectiveness of these programs is still not available. The Reference Committee believes this to be an informative and useful report. However, since some speakers indicated that there may be some negative health effects associated with delaying medical care while a second opinion is being sought, the Reference Committee believes that the results of second surgical opinion programs should continue to be monitored.

The Ohio Delegation voted unanimously in favor of filing the report.

**A report on the
1982 Annual
Business Meeting
of the American
Medical
Association.**

Repeal of Health Planning Act

The American Medical Association House of Delegates adopted a resolution that calls on the Association to continue to support H.R. 4554 and any other bills which repeal the federal Health Planning Act. The adopted resolution was amended to state additionally that the American Medical Association continue to support efforts to repeal the federal Health Planning Act.

The Ohio Delegation was in unanimous support of adoption of this amended resolution.

Physicians as Independent Contractors

The American Medical Association House of Delegates adopted a Board of Trustees report dealing with S. 8, the Employment Tax Act of 1981. S. 8 establishes criteria for independent contractors for tax purposes. The criteria include: (1) control of hours worked; (2) place of business; (3) investment or income fluctuation; (4) written contract and notice of tax responsibilities; and (5) filing of returns.

The adopted Board of Trustees report includes the following statement:

"The Board has reviewed and approved draft amendments to S. 8 that have been developed by the Council on Legislation to help assure that hospital-based and hospital-associated physicians who currently treat themselves as independent contractors for tax purposes could continue to be so classified. The amendments have met with the approval of representatives of the medical specialty societies most directly concerned with this issue. The Congressional committees have received these recommended amendments, and the Board will continue to monitor developments relating to this subject."

The Ohio Delegation was in unanimous support of adoption of this report.

State Regulation of Professional Liability Insurance

The American Medical Association

House of Delegates adopted the following amended resolution:

"RESOLVED, That the American Medical Association support the current system of state regulation of professional liability insurance and oppose any effort by the federal government to preempt this right of the states."

The Ohio Delegation was in unanimous support of the amended resolution.

Proposed Pension Reforms

The American Medical Association House of Delegates adopted the following substitute resolution:

"RESOLVED, That the American Medical Association continue to support equity in pension plans, including appropriate increases in the maximum contribution to self-employed retirement plans (Keogh), and actively oppose enactment of H.R. 6410, the Pension Equity Tax Act of 1982, in its form as introduced because of its major discriminatory provisions.

Reference Committee comment: "Resolution 84 put AMA on record in strong opposition to H.R. 6410 (Pension Equity Tax Act of 1982), and similar legislation, and to inform appropriate Congressional bodies of this strong opposition.

The Reference Committee was advised that one provision of H.R. 6410 would increase the maximum contribution allowable into a Keogh plan, but the principal provisions of the bill would discriminate against professional service corporations and also adversely affect employee benefit plans. The Committee is aware that the Council on Legislation and the Board of Trustees have already adopted positions on this legislation, recommending support for an increase in the allowable Keogh contributions, but opposition to H.R. 6410 as written. Testimony at the hearing was unanimous in opposition to this legislation. The Committee commended the Board and Council for their prompt response to this legislation."

The Ohio Delegation was in unanimous support of this substitute resolution.

Federal Trade Commission

The American Medical Association House of Delegates adopted two Board of Trustees reports and three resolutions regarding the Federal Trade Commission (FTC). The major theme of the reports and resolutions is that the American Medical Association strongly supports S. 1984 limiting Federal Trade Commission jurisdiction over the learned professions and H.R. 3722 imposing a moratorium on FTC activity relative to the learned professions. The Board of Trustees will continue to pursue vigorously all activities to effectuate an appropriate resolution to the problems resulting from improper FTC regulation of the professions.

The Ohio Delegation was in unanimous support of the adoption of the reports and resolutions.

Defaulted Government Loans

The American Medical Association House of Delegates adopted the following resolution:

"RESOLVED, That the American Medical Association urge increased efforts to collect overdue debts from the present medical student loan programs in a manner that would not interfere with the provision of future loan funds to medical students; and be it further

RESOLVED, That the AMA encourage medical school financial aid officers to counsel individual medical student borrowers on the status of their indebtedness and payment schedules prior to their graduation."

The Ohio Delegation was in unanimous support of adoption of this resolution.

Foreign Medical Schools and Foreign Medical Graduates

The American Medical Association House of Delegates adopted an amended Council on Medical Education report summarizing that the Council believes that persons educated in foreign countries who apply for positions in accredited programs of graduate medical education should be evaluated for clinical and scientific knowledge and skills in a manner that

assures their comparability to graduates of United States medical schools.

The Ohio Delegation was in unanimous support of adoption of this amended report.

Satellite Emergency Clinics

The American Medical Association House of Delegates referred back to the Board of Trustees a report on satellite emergency clinics. The Board was requested to make inquiries and provide comprehensive information to physicians regarding the emergence and development of satellite clinics in the provision of medical services; and that information be developed to inform physicians what they may lawfully do in meeting this competitive challenge.

The Ohio Delegation unanimously supported referral.

Free-Standing Emergency Medical Centers

The American Medical Association House of Delegates referred back to the Board of Trustees a report on free-standing emergency medical centers for further study. The referred report recommended several desirable elements for such centers, including: hours of operation, staffing and medical direction, relationship to the emergency medical services system, ancillary services and equipment, protocols, private physician referrals, medical records and payment for services.

The Reference Committee recommendation for referral for further study was based on strong testimony before the Committee regarding definition of emergency care centers and more specific safeguards for continuity of care.

The Ohio Delegation unanimously supported referral.

Physicians Desk Reference

The American Medical Association House of Delegates referred to the Board of Trustees a resolution on the Physicians Desk Reference. The referred resolution asked the AMA to promulgate to the general public that the Physicians Desk Reference (PDR)

is not a standard of practice in medicine but one of a multitude of books, literature, journals and clinical experience which serves as a resource for a physician in the practice of medicine.

The Ohio Delegation unanimously supported referral of this resolution.

Fetal Effects of Maternal Alcohol Use

The American Medical Association adopted a Council on Scientific Affairs report on fetal effects of maternal alcohol use. The report dealt with facial features, prenatal and postnatal growth deficiency, central nervous system dysfunction and malformations.

The Ohio Delegation was in unanimous support of adoption.

Hospital/Health Facility Medical Staff Membership in the AMA

The American Medical Association House of Delegates adopted a heavily amended Board of Trustees report dealing with changing medical care environment, trends in hospital structure and management for the 1980s, medical staff issues and problems, and the role of organized medicine.

The Ohio Delegation unanimously supported adoption.

Development of a National Health Policy

The American Medical Association House of Delegates adopted a Board of Trustees report stating that the Association is embarking on activities to develop a National Health Policy. A variety of professional, business, labor and insurance organizations would be invited to participate in this effort to establish the private sector's view of what should be the national agenda for dealing with health issues.

The Ohio Delegation supported adoption of this report.

Medical Student Recruitment and Enrollment in Organized Medicine

The AMA House of Delegates referred a resolution to the Board of

Trustees suggesting that the American Medical Association study the membership recruitment activities of state medical societies and report on the impact of these activities on the composition of the House of Delegates.

Reference Committee comment: The Board and two AMA Councils currently are studying the Size and Composition of the House. It would appear most appropriate for this resolution to be considered in the context of that study.

The Ohio Delegation unanimously supported referral.

HMO Advertising

The American Medical Association House of Delegates adopted the following amended substitute resolution on HMO advertising:

"RESOLVED, That the American Medical Association reaffirm its strong stand against the Department of Health and Human Services' use of advertisements and other promotional mailings designed to encourage Medicare beneficiaries' enrollment in a Health Maintenance Organization; and be it further;

RESOLVED, That the AMA continue to seek legislation that would prohibit the use of public funds to promote *one form of medical care delivery over another, especially the promotion to Medicare beneficiaries of enrollment in HMOs.*

The Ohio Delegation unanimously supported adoption.

Implementation of Voluntary Medical Peer Review

The American Medical Association House of Delegates adopted a Council on Medical Service report that describes alternative strategies for implementing voluntary medical peer review and makes recommendations on policy and future activity.

The Ohio Delegation unanimously supported adoption.

Evaluation of AMA Policy on Nurse Practitioners

The AMA House of Delegates referred to the Board of Trustees a report reviewing activities of the Board of Trustees on the role of nurse

practitioners and AMA policy. These activities include meetings with nursing organizations and a review of the comments on the Initial Report and Preliminary Recommendations of the National Commission on Nursing. The Board recommends that the AMA (1) continue to monitor and review developments relating to nurse practitioners, and (2) maintain a neutral policy position.

The Ohio Delegation was unanimous in support of referral.

Prevention of Deaths and Injuries From Automobile Accidents

The American Medical Association House of Delegates adopted the following substitute resolution:

"RESOLVED, That the American Medical Association urge the federation to support legislation such as that passed in many states mandating the use of seatbelts for occupants of motor vehicles; and be it further

RESOLVED, That the AMA urge the federation to support legislation requiring the passive restraint of infants and children in motor vehicles."

The Ohio Delegation unanimously supported adoption.

Medical Consequences of Nuclear War, Prevention of Nuclear War, Proposed Crisis Relocation and Shelter Plans

The AMA House of Delegates adopted a Board of Trustees report and a resolution on the above subjects. The Board of Trustees report is an informational status report listing the several activities accomplished by the AMA regarding the medical consequences of nuclear war. The Resolution asks the AMA to study the medical effectiveness of the relocation and shelter plans proposed by the Federal Emergency Management Agency, and report back to the House at the 1982 Interim Meeting.

The Ohio Delegation unanimously supported adoption.

There are many excellent reports presented to the House of Delegates at each meeting, covering a wide range of subjects that are of interest to physicians. These reports, prepared by AMA councils, committees and staff, contain a wealth of information.

A listing, by title, of some of the reports follows. If you would like a copy of any or all of these reports, please contact the OSMA office.

1. American Medical Assurance

Company

2. Status Report on AMA Activities Relating to Increased State Responsibilities for Health Programs
3. Remedial Antitrust Legislation
4. Clean Air Act
5. Physician Mortality Project: Description and Preliminary Findings
6. Essentials for the Accreditation of Sponsors of Continuing Medical Education
7. Medicare Reimbursement
8. Physician-Patient Relationship
9. Third-Party Coverage for Psychiatric Services
10. Continuous Ambulatory Peritoneal Dialysis
11. Infant Formula Marketing
12. Medical Evaluation of Healthy Persons
13. Sodium in Processed Foods
14. Explanation of Medicare Benefits (EOMB) Form
15. Health Manpower
16. Fetal Effects of Maternal Alcohol Use

Dr. Clarke, Gallipolis, is the Chairman of the Ohio Delegation to the AMA. Dr. Ford, Toledo, is President of the OSMA, and Co-Chairman of the Ohio Delegation.



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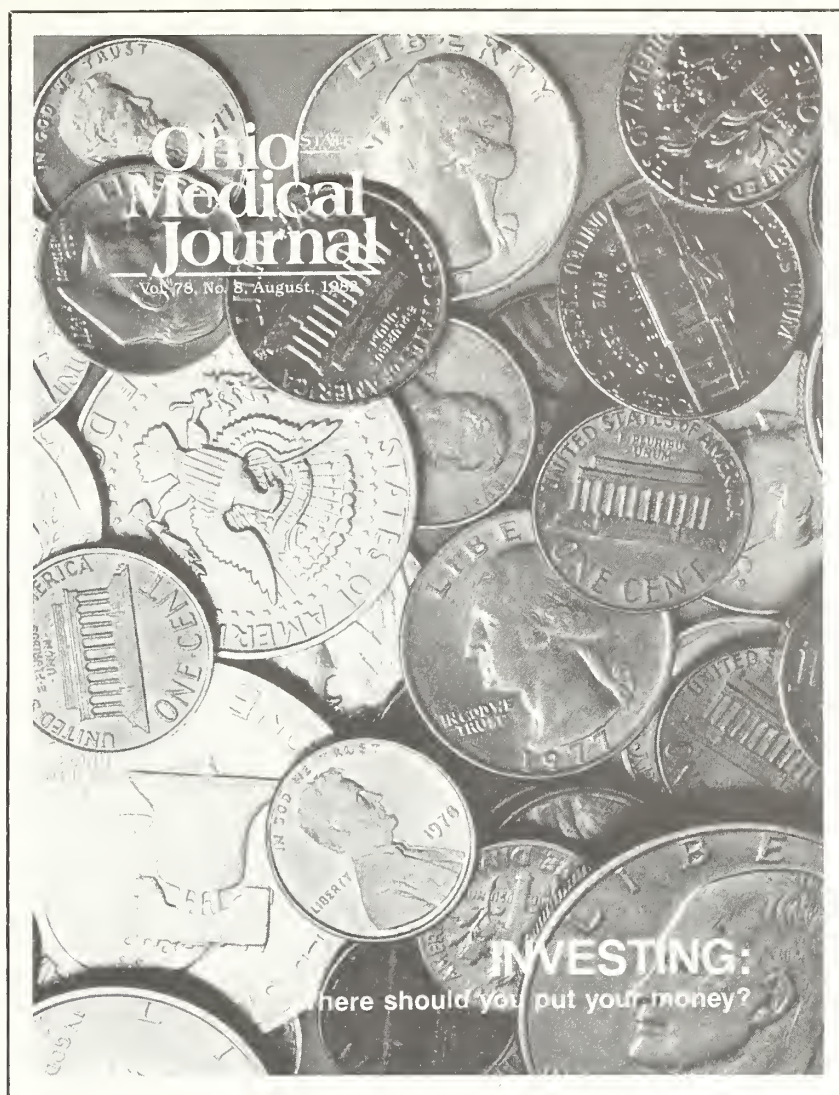
President

MEMBER: American Hospital Association—National Association of Private Psychiatric Hospitals

Colleagues in the News (continued)

of staff of Medical College of Ohio Hospital, Toledo. Also installed were JOEL P. ZRULL, M.D., professor and chairman, department of psychiatry, vice chief of staff, and AMIRA F. GOHARA, M.D., secretary.

Faculty appointments to the Northeastern Ohio Universities College of Medicine are PAUL T. ROGERS, M.D., pediatrics, as assistant professor of pediatrics, and FRANCIS J. WAICKMAN, M.D., allergy-immunology, as clinical assistant professor of pediatrics.



INVESTING:

Where should you put your money?

**Stocks, Bonds and Other
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William A. Clark

**Gold! Midas or Madness? . . .
545**
Joan S. Fulton

**Real Estate Investing: Returns
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Richard L. Royer

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Jack Valancy

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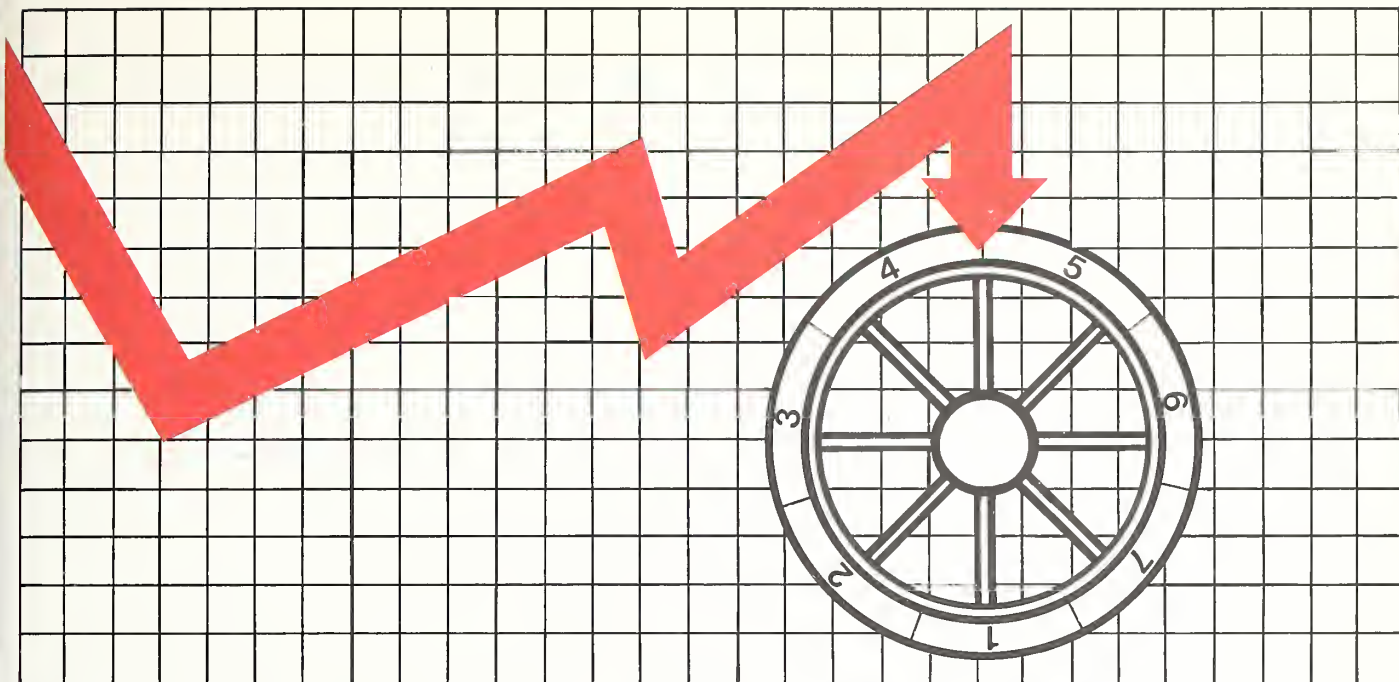
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Stocks, Bonds . . . and Other Games of Chance

By William A. Clark

How is your financial health?

Every physician should be able to answer this question satisfactorily, just as he determines the physical health of his patients. Yet, the financial area seems to be one of the most neglected areas of a doctor's life. Most doctors quickly become so engrossed in the pressures and demands of their practice, that they seldom devote the necessary time and effort to plan for their financial future. In the business of investment counselling, I have talked to hundreds of doctors over many years. I am continually surprised at how poorly many of them have managed their finances! As a group, doctors enjoy one of the highest levels of compensation of any professional field. Yet, the vast majority would get very low grades on how well they have conserved those assets and made them grow. This isn't meant to be overly critical of doctors, since successful investing is difficult for everyone. It's easy to become

disillusioned, depressed, and fearful of investing. It doesn't take many mistakes or unhappy experiences to make one want to "sell everything" and put his assets in cash where he

It doesn't take many mistakes to make one want to "sell everything" and put their assets in cash . . . but, of course, this doesn't work either.

can hold on to it. But of course this doesn't work either, since taxes take much of this, and cash has a way of slipping away for the pleasures of life. Doctors as a group also seem to be the

prime targets of every wild, speculative investment scheme known. It becomes very difficult for a doctor to separate good, sound investment advice, from hot tips and totally unsuitable promotions. However, many doctors make just as serious a mistake by doing nothing. How then, can a doctor invest successfully? The answer is really simple. **Develop a plan** that will give you financial security now, and also when you retire. In developing your financial program, it is essential that you find a reputable investment firm. This kind of firm will have good research and many different types of investment alternatives to recommend. Their integrity in dealing with investors over the years should assure you of being treated fairly. Equally as important is to find an honest, experienced investment representative with whom you are comfortable. You should be open with him, and give him time to

earn your trust and confidence. As he gets to know you, your personality, and your objectives, he will be better able to give you good investment ideas. Sound investment advice should be rewarded by your loyalty. Many doctors treat investing as they would buying an automobile or a suit of clothes. Some persist in "shopping around" continually and getting advice from everyone from the hospital to the cocktail party. It is difficult to manage an investment portfolio from the original plan when ideas are continually being injected from outside sources. Having developed a plan, found a reputable firm, and an experienced advisor, what do we do now?

1. Develop discipline - stick to the plan.
2. Develop persistence - add new funds regularly.
3. Develop patience - achieving your goals will not happen overnight. It will take years. Mistakes may be made, but discipline, patience, and perseverance will ultimately put you close to your goals.

I have found three main types of practice, each indicating a slightly different approach.

- A. Individual practice
- B. Partnership or group practice
- C. Incorporation

The type of practice or corporate set-up determines to some extent the investment strategy. A doctor usually has several different areas of investment needs which are listed below:

1. Personal account
2. Children's accounts
3. Corporate account

A portfolio of investments for the personal account should usually include growth stocks which have good potential for capital gain over the years. Income is not important in this account, since it is not needed, for living expenses. Presumably taxes would also take back much of the income. Tax-free income, however, is essential. This leads to municipal bonds which insure high return, safety and tax-free income. An IRA account now can be added to this personal account thus giving an additional

\$2,000 per year tax sheltered investment. For some individuals, a margin account will enhance the growth of the portfolio by leveraging available funds. Margin accounts should be used carefully when market conditions are bullish, interest rates are not excessive, and the risk-reward ratio is understood. Tax shelters also should be considered in the personal account. Care should be exercised here also to select only those managed and recommended by reputable people. They should provide a valuable asset or a reasonable chance for payback of investment over a 3- to 5-year period. Some real estate and some oil and gas tax shelters can meet these criteria.

If there are children in the family, an investment program should be set up immediately for them. This will provide tax-sheltered income and growth for their future needs, such as

If there are children in the family, an investment program should be set up immediately for them.

education and marriage. This can be accomplished with a custodian account for each child, with one parent acting as custodian. The custodian has complete control and jurisdiction over the handling of this account until the child becomes of age. However, investments made in a custodian account constitute a gift to the child, thereby shifting any taxes incurred from the parents to the child. With educational costs skyrocketing annually, a custodian account should be started as early as possible. It also has a fine educational benefit for the child in teaching the value of earning, investing, and the concept of the free enterprise system.

The most important area of investing for the doctor is that which will provide him with a pension or profit sharing account at retirement. Most group practices have corporate pension and/or profit sharing plans.

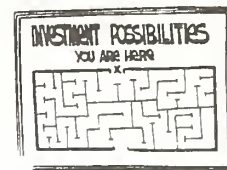
These usually are managed professionally and each doctor shares in his proportionate funding as well as the income and growth of the fund. Many types of management may be selected. Group plans can be set up so each doctor can individually determine investments under the corporate trustee plan. A doctor who is incorporated can set up both pension and profit sharing plans, if desired. The investment objectives of this account are different than the personal account. Since the taxes are completely deferred until withdrawal or retirement, maximum total return on the investment is the objective. A portfolio should be built by diversifying as much as possible, since this is a retirement account with fiduciary responsibility. Fixed income corporate bonds will give high yield and safety to that portion. Growth stocks can be added to give appreciation and enhance total return. Since there are no taxes to consider, investments can be switched without tax concerns. The degree of concentration or speculation in such an account should be determined by the objectives of the doctor and employees involved. Real estate and other types of investments can be added if suitable. There are other advantages to these pension plans. Money can be borrowed from the pension account, but must be paid back later. Care should be exercised in this practice, however, since borrowed funds won't grow and the years go by fast. Early retirement due to health or other reasons could cause financial crises if you haven't been diligent in building your retirement fund.

In summary, I should say I believe firmly in the benefits of good sound systematic investing for everyone. The physician can benefit more than most if he develops a plan, is disciplined, persistent, and patient.

William A. Clark has a degree in engineering, with postgraduate education in finance. He has been with The Ohio Company for twenty-two years, and is currently Vice President, managing individual as well as institutional accounts.



How to talk like an investor



(From the booklet "Investing in municipal bonds for tax-free income," a publication of Merrill, Lynch, Pierce, Fenner & Smith, Inc., excerpted with their permission.)

Glossary

accrued interest

Interest due from the last interest payment to the present day. When you buy a bond, you must pay the seller the accrued interest, and when you sell, the buyer pays you.

amortize

To pay off a debt by periodic payments set aside for the purpose.

bearer bond

A bond which is presumed to be owned by the person who has possession of it; the owner's name is not on record with the issuer.

blue list

The trade offering sheets of bond dealers, which list dealers' offerings of municipal bonds for sale all over the country.

bond

A written promise to pay a fixed amount of borrowed money on a specified date and to pay a set annual rate of interest in the meantime.

call provision

A bond with a call provision may be redeemed at the option of the issuer before maturity, usually at a premium.

coupon

Evidence of interest due on a bond, usually every six months. With a bearer bond, the coupon is detached from the bond and presented for payment of interest to the issuer's agent or the bondholder's bank.

coupon rate

The annual rate of interest which the borrower promises to pay the bondholder.

current yield

The percent relation of the annual interest received to the price of the bond (coupon ÷ price)

discount

The difference between the price of a bond and its value at maturity, when the price is lower than the maturity value.

general obligation bonds

Bonds secured by the full faith, credit, and generally the unlimited taxing power of the issuer.

interest

Money paid for the use of money.

legal opinion

An opinion about the legality of a bond issue under the laws that affect it, usually issued by a firm of attorneys specializing in public borrowing.

limited tax bond

A bond which is secured by a tax which is limited as to rate and amount.

maturity

The date on which the bond principal or stated value becomes due and payable in full to the bondholder.

moral obligation bond

One which is primarily secured by project revenues and has the "moral"

pledge of a state to make up any deficiency in the capital reserve fund of the issue in the event that revenues are insufficient to cover debt service.

municipal bond fund

Municipal bond funds are tax-exempt funds which offer continuous professional management of a diversified portfolio of municipal bonds which may have varying maturities.

municipal bond trust

Municipal bond trusts are unit investment trusts which consist of fixed portfolios of municipal bonds that are initially purchased for each trust and usually remain in the portfolio until maturity unless the bonds are called before maturity.

public housing authority bonds

Bonds issued by a local Public Housing Authority to finance public housing and backed by Federal funds.

over-the-counter market

Securities market conducted by private negotiation among dealers all over the country. All municipal bonds are traded over-the-counter as opposed to being traded on an exchange.

par value

The principal amount of a bond; the amount of money due at maturity.

premium

The difference between the price of a bond and its value at maturity, when the price is higher than the maturity value.

continued on page 574

HYPERTENSION:



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INDERAL is contraindicated in: 1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with INDERAL, 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE. Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta-blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. INDERAL acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by INDERAL's negative inotropic effect. The effects of INDERAL and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during INDERAL therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, INDERAL therapy should be immediately withdrawn, b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS DURING ANESTHESIA with agents that require catecholamine release for maintenance of adequate cardiac function, beta blockade will impair the desired inotropic effect. Therefore, INDERAL should be titrated carefully when administered for arrhythmias occurring during anesthesia.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, INDERAL should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since INDERAL is a competitive inhibitor of beta receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), INDERAL should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA. Because of its beta-adrenergic blocking activity, INDERAL may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

USE IN PREGNANCY. The safe use of INDERAL in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit.

Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if INDERAL is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of INDERAL may produce hypotension and/or marked bradycardia resulting in vertigo, syncope attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Miscellaneous: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

ORAL

DOSEAGE AND ADMINISTRATION

HYPERTENSION—Dosage must be individualized. The usual initial dosage is 40 mg INDERAL twice daily, whether used alone or added to a diuretic. Dosage may be increased gradually until adequate blood pressure is achieved. The usual dosage is 160 to 480 mg per day. In some instances a dosage of 640 mg may be required. The time needed for full hypertensive response to a given dosage is variable and may range from a few days to several weeks.

While twice-daily dosing is effective and can maintain a reduction in blood pressure throughout the day, some patients, especially when lower doses are used, may experience a modest rise in blood pressure toward the end of the 12 hour dosing interval. This can be evaluated by measuring blood pressure near the end of the dosing interval to determine whether satisfactory control is being maintained throughout the day. If control is not adequate, a larger dose, or 3 times daily therapy may achieve better control.

PEDIATRIC DOSAGE

At this time the data on the use of the drug in this age group are too limited to permit adequate directions for use.

INTRAVENOUS

The intravenous administration of INDERAL has not been evaluated adequately in the management of hypertensive emergencies.

OVERDOSAGE OR EXAGGERATED RESPONSE

IN THE EVENT OF OVERDOSAGE OR EXAGGERATED RESPONSE, THE FOLLOWING MEASURES SHOULD BE EMPLOYED:

BRADYCARDIA—ADMINISTER ATROPINE (0.25 to 1.0 mg). IF THERE IS NO RE-

SPONSE TO VAGAL BLOCKADE, ADMINISTER ISOPROTERENOL CAUTIOUSLY.

CARDIAC FAILURE—DIGITALIZATION AND DIURETICS.

HYPOTENSION—VASOPRESSORS, e.g., LEVATERENOL OR EPINEPHRINE (THERE IS EVIDENCE THAT EPINEPHRINE IS THE DRUG OF CHOICE).

BRONCHOSPASM—ADMINISTER ISOPROTERENOL AND AMINOPHYLLINE.

HOW SUPPLIED

INDERAL (propranolol hydrochloride)

TABLETS

No. 461—Each scored tablet contains 10 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 462—Each scored tablet contains 20 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 464—Each scored tablet contains 40 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 468—Each scored tablet contains 80 mg of propranolol hydrochloride, in bottles of 100 and 1,000. Also in unit dose package of 100.

INJECTABLE

No. 3265—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10.

Reference: 1. Freis, E. D. Hypertension (Suppl. II) 3:230 (Nov-Dec) 1981

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Real Estate Investing:

Returns to the Land

By Richard L. Royer



In many respects, there may never have been a better time for investing in real estate. The circumstances of the current economic recession in the U.S. which have depressed the value of most other investments, have produced a sounder American dollar and reinforced the evidence that real estate is always one of the soundest investment choices, even in a period when the rate of appreciation on the investment has been slowed down.

The basics of real estate as an investment haven't changed. An investor wants to do three things: Make sure his money is safe, earn a return on it, and assure that it grows.

I should note that I have reversed the normal order of a couple of those. In the past, the order used to be return, growth and safety of the investment, but now safety of the money has become paramount because of changes in our economy. And measuring the return should be done regularly to take into consideration factors of depreciation and tax advantages related to the real estate ownership — matters demanding current knowledge because legislation has a changing effect on those things.

Real estate professionals have had a couple of rocky years, but the smart

ones can read the positive indicators of what's to come in the future. The picture is bright for real estate investment.

Consider what is immediately behind us:

The present federal administration and compliant Congress put economic policies in place which were intended to wring spiraling inflation out of the American economy. That brought on tight money and high interest rates to all borrowers.

Those policies have depressed the real estate marketplace, but it is a

To illustrate, MONEY magazine published an investment scorecard recently pegged on 1981 economic activity, and housing as one aspect of the real estate marketplace showed a gain of 3 percent in investment value while everything else on the list except mutual funds (up a slim four one-hundredths of a percent) took a slide.

Other investments on the scorecard were: stocks, minus 8 percent; bonds, minus 5 percent; gold, minus 33 percent; silver, minus 50 percent; commodities, minus 18 percent; diamonds, minus 38 percent; and

Real estate professionals have had a couple of rocky years, but the smart ones can read the positive indicators of what's to come . . . the picture is bright for investment.

temporary condition which inevitably will be reversed because of the pent-up demand pressure which REALTORS are most conscious of. Even with those policies, real estate has held up fairly well as a sound investment while other investments have taken a beating.

collectibles, minus 4 percent.

How does real estate as an investment manage to hold up so well? There are several basic explanations, some historic and some born of the new conditions in the U.S. economy.

First, real estate is universal and it is

Real Estate Investing: Returns to the Land

limited in supply.

Second, the rate of renewal or replacement of housing and commercial/industrial building stock has been slowed down dramatically by the tight money and high interest rates of the real estate marketplace over the past two years. That adds to the demand pressure in the face of the already limited supply.

Third, the population bulge in the pool of prime age (25-35) prospective home buyers is the largest in the nation's history, translating into a tremendous pent-up demand currently, and the expected business recovery in late 1982 or early 1983 exerts demand pressure for commercial and industrial property.

And fourth, new experience in seller financing and other innovative financing techniques has kept the real estate market alive if not thriving.

Traditionally, real estate has grown in value at a steady pace and has outpaced most other investments.

physically or make adjustments in the form of higher rents, lower expenses, etc. At least you can take some action to control your economic fate, to a certain extent.

If you have a share of corporation stock and it goes down in value because the corporation had a poor quarter, there isn't a thing you can do about it to change the facts. You really are faced with a single set of options: you can sell it or hold it at less value.

With a real estate investment, you can get out and paint it, raise the rent, try to double the number of units, do remodeling — you've got control over some choice.

In addition, real estate still is the best source of leverage for an investment. You usually can borrow more on it than you can on alternative investments and your income from the property will amortize the debt.

Real estate is a terrific estate builder. Such ownership is a forced savings plan, in effect, as you pay off the

high — one of the few perceived negatives of such investments. But the facts are that there are owners who want to sell and are providing good leverage through seller financing, which offers below-market interest rates.

This period is providing one of the best opportunities in our history to buy real estate at a discount advantage, because of the alternative financing available. The timing is right for those who have been considering real estate investment.

Are there other negative aspects? Only a few, which are greatly outweighed by the advantages, and a good REALTOR will lay them right out.

One of the negatives is the illiquidity of real estate, meaning that a sale to convert the ownership into cash may not occur as quickly as some sellers may desire. But it's an illiquidity problem, not a nonliquidity one — a problem only temporarily difficult to deal with.

Another negative aspect is that the property may require personal management — maintenance concerns, rent collection. Obviously, those are matters a busy and successful physician is not going to want to get tied down with, but there are real estate professionals who specialize in property management and perform that service for investors.

And one more negative is that it is difficult to value real estate because it is not standardized, like a share of stock is. Its market is diversified and every piece of real estate in the world is different, if only by virtue of location. So there again, an investor should have the help of a real estate professional, this time somebody technically trained in making real estate analysis.

I can't overstate the counsel to seek the service of the appropriate real estate specialist in real estate investments. The real estate profession, like the medical profession, has numerous specialists.

Real estate investment offers the investor some individual control. At least you can take some action to control your economic fate . . .

During the 1970s, a decade in which real estate experienced both a recession and a boom, it appreciated in value in a range of 5 to 14 percent. In the last years of the decade, and before the present policies calculated to force down American inflation rates, the rate of appreciation in real estate was 10-12 percent a year.

There are other ongoing reasons why real estate is a positive form of investment.

Real estate ownership provides a strong and stable financial base. It should be part of everyone's investment portfolio. These days there are good arguments for diversification, but real estate should be part of any thinking investor's portfolio.

Real estate investment offers the investor some individual control. It's a commodity that you can change

mortgage. A growing number of people these days will invest by making a down payment on two or three pieces of property, recognizing that in 20 years they can own them free and clear, with a tremendous return on the initial down payment.

Investment real estate has not been built in any substantial quantity in this country during the past few years while population has grown. That means there is great existing and potential demand for such property. REALTORS also believe that values of existing real estate will be maintained and value of new units will be higher because of increasing construction costs.

Some people have tended to shy away from investment property because they think the quoted interest rate or investment real estate is too

continued on page 574

First Class First Aid

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NEOSPORIN[®] Ointment

(POLYMYXIN B-BACITRACIN-NEOMYCIN)

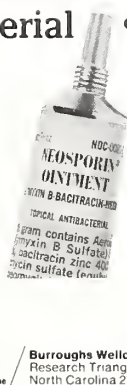
- Broad-spectrum antibacterial
- Handy applicator tip

DESCRIPTION: Each gram contains: Aerosporin[®] (Polymyxin B Sulfate) 5,000 units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base); special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: Therapeutically (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: • infected burns, skin grafts, surgical incisions, otitis externa • primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia) • secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis) • traumatic lesions, inflamed or suppurating as a result of bacterial infection. Prophylactically the ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: Not for use in the eyes or in the external ear canal if the eardrum is perforated. This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neo-



mycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching. It may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



Burroughs Wellcome Co.
Research Triangle Park
North Carolina 27709

Antiques

Killings with Class

By James T. Lowder

Several years ago, during a brief career of dealing in antiques, my wife Ann and I were exhibiting in our first major antiques show. During a lull on the second day we noticed a small group of veteran dealers had found something very amusing. Inviting ourselves into this private hilarity, we discovered that they were laughing about a lady's purchases. Noticing my puzzlement, they explained, "She is a doctor's wife and has been all over the show explaining that her husband had such bad luck in the stock market that he was selling all his stocks and suggested that she 'invest in antiques.' "It seems that he had read how antiques were doing much better than stocks. And apparently she was taking her task seriously, having spent several thousand dollars in the past few hours. The funny part (or sad, depending upon your perspective) was that she was missing some of the truly great pieces in the show and was buying "pretty pieces!"

With no one to guide her, she was simply inviting various dealers to give her their best spiel about items that caught her fancy. If I recall correctly, she had just concluded the purchase of a highly restored English chest of drawers that had actually been made years later than its style would suggest. It had a nice formal look that was appealing but of no great value. In the process of buying what she liked she passed two great decorated cupboards, a magnificent stag weathervane and a Philadelphia lowboy, items that today would be valued two to five times their cost.

I have often wondered how this couple's "investments" in antiques fared! It is possible that they "lucked out," simply because the time from 1975 to 1980 will be remembered for the steady growth in interest in antiques and an upward spiral in their value. It was a period in which we annually reported record-breaking auction prices for Americana. While in some quarters the auction records were pooh-poohed, we saw these as only the tip of the iceberg, stabilized

The increases in values of American antiques were such that it even made sense to borrow money in order to collect. . .

by private transactions of even greater magnitude. Along with the record breakers, the rest of the market enjoyed dramatic increases and even the low end and marginal items gained significantly. Throughout this period, the increases in values of American antiques were such that it even made sense to borrow money in order to collect.

The Sotheby Index, published weekly in *Barrons*, illustrates the 1975-1980 period. Experts will certainly disagree with the specific numbers. Also, it should be mentioned that the indices have no greater relation to

individual pieces than does the Dow-Jones to individual stocks. But look at the trend! Based on an aggregate index of 100 in 1975, values averaged to an aggregate of 253 in 1980, according to Sotheby's records. This is analogous to a move of the Dow-Jones from 800 to 2,000! No wonder there was increased interest in the investment potential of art and antiques in the late 1970s!

The '70s produced many changes in the antiques market. Publishing flourished¹ in response to the increased demand for information; promotion fanned the flames of casual interest into avidness. The nostalgic "country look" captured the imagination of the young marrieds. Dealers were amazed at the youth and knowledge of the new collectors and at their money. Dealers who still remembered the depression and had gone without to pay \$20 for that spider-leg candlestand could not easily understand the young couple paying \$800 for it. Some dealers, unable to cope with rapidly accelerating values, continued to deal in what they could buy for X and sell for Y, and fell out of the Americana market. Others, able to adapt, marveled at the changes but kept pace.

The increase in knowledgeable collectors and buyers surfaced at auctions and a revolution occurred. Dealers, pickers, and a handful of collectors no longer could dominate the auctions. The auction houses recognized and capitalized on their new audience. Pools (a group of dealers and/or collectors who

continued on page 541

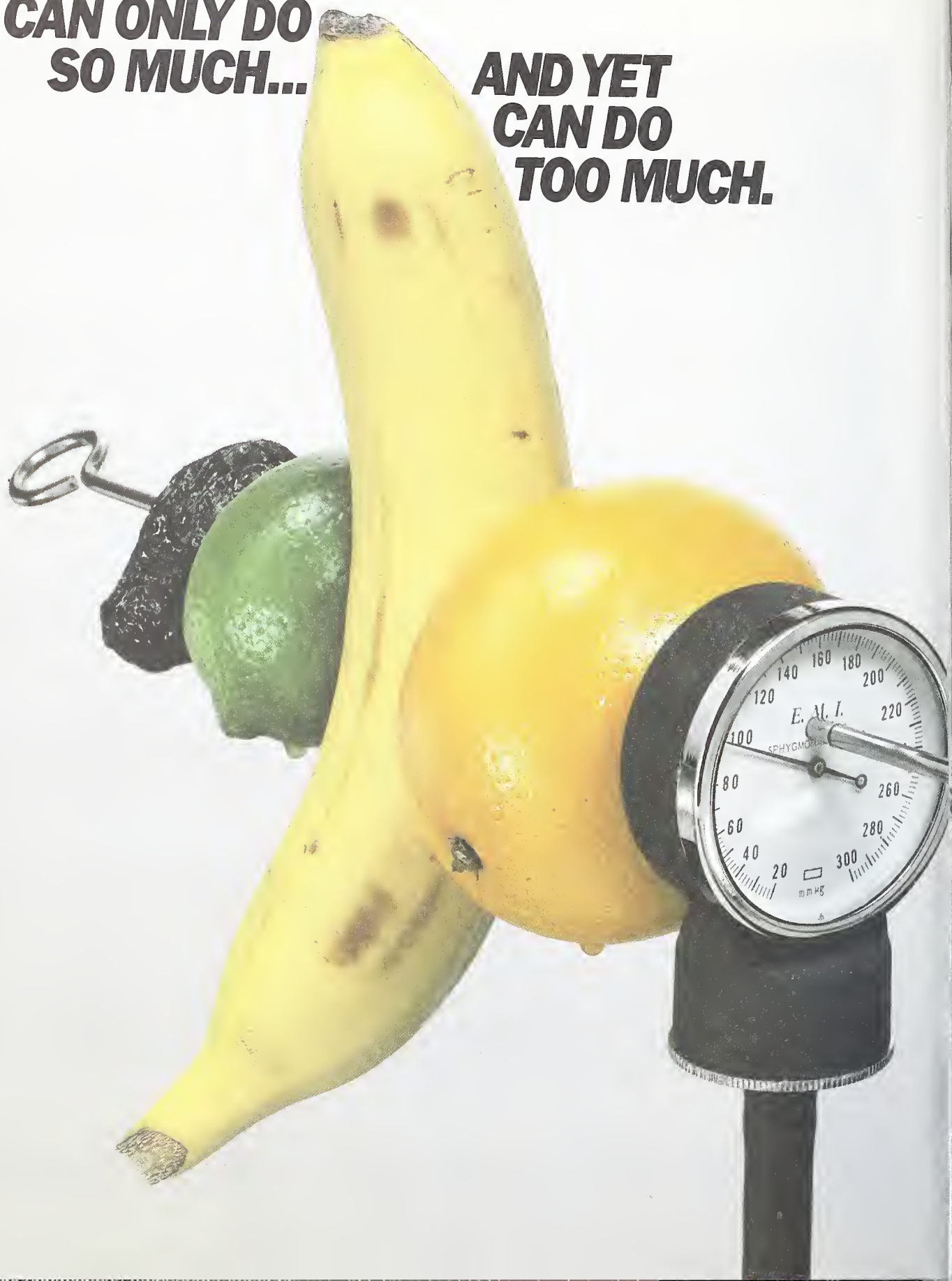
At right

Sold at a New Jersey auction on November 18, 1972 for \$11,000, this molded copper Statue of Liberty weathervane was made by the J. L. Mott Iron Works in the late 19th century. It reached the highest price ever paid at auction for a weathervane on April 29th of this year at Sotheby's in New York City, selling for \$82,500. (Photo courtesy of Sotheby Parke Bernet.)



**BECAUSE
A THIAZIDE ALONE
CAN ONLY DO
SO MUCH...**

**AND YET
CAN DO
TOO MUCH.**



INCREASE CONTROL WITHOUT INCREASING POTASSIUM PROBLEMS.

A dependable means to long-term blood pressure control.

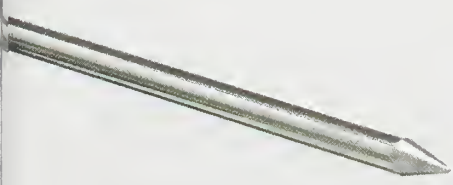
Many times, a diuretic alone can't keep hypertension in check. *INDERIDE*, however, can pick up where thiazide therapy leaves off.

The combination of propranolol HCl, the world's most trusted beta blocker, and hydrochlorothiazide, the standard among diuretics, enables *INDERIDE* to exert an additive antihypertensive effect.^{1,2} In fact, a propranolol/hydrochlorothiazide regimen maintained blood pressure below 90 mm Hg in 81.8% to 86.4% of patients followed for 6 to 18 months of therapy.¹

Low thiazide dosage means reduced risk of hypokalemia.

When thiazides are prescribed in doses greater than 50 mg/day, the potential for hypokalemia increases substantially. What's more, the greater the fall in serum K⁺, the greater the risk of hypokalemia-induced PVCs.^{3,4}

With *INDERIDE*, the additive hypotensive effect of propranolol HCl allows the effective dose of hydrochlorothiazide to be kept low (25 mg b.i.d.). And by lowering the daily dose of diuretic, *INDERIDE* also lowers the potential for diuretic-induced side effects. Potassium problems are less likely to occur—yet blood pressure can be controlled consistently.



INDERIDE[®]

Each tablet contains *INDERAL*[®] (propranolol HCl) 40 mg or 80 mg,
and hydrochlorothiazide 25 mg | **B.I.D. 40/25
80/25**

When you know you need more than a thiazide.

Please see Brief Summary of Prescribing Information on following page.

BRIEF SUMMARY
(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)

INDERIDE®

BRAND OF
propranolol hydrochloride
(INDERAL®)
and hydrochlorothiazide

No. 474—Each IINDERIDE®-40/25 tablet contains Propranolol hydrochloride (INDERAL®)	40 mg
Hydrochlorothiazide	25 mg
No. 476—Each IINDERIDE®-80/25 tablet contains Propranolol hydrochloride (INDERAL®)	80 mg
Hydrochlorothiazide	25 mg

WARNING: This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

DESCRIPTION: IINDERIDE combines two antihypertensive agents. IINDERAL (propranolol hydrochloride), a beta-adrenergic blocking agent, and hydrochlorothiazide, a thiazide diuretic-antihypertensive.

INDICATION: IINDERIDE is indicated in the management of hypertension. (See boxed warning.)

CONTRAINDICATIONS: Propranolol hydrochloride (INDERAL®): Propranolol hydrochloride is contraindicated in: 1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS); unless the failure is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors); and during the two week withdrawal period from such drugs.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS: Propranolol hydrochloride (INDERAL®): CARDIAC FAILURE: Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn, b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of propranolol therapy. Therefore, when discontinuation of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

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IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA: Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

USE IN PREGNANCY: Propranolol hydrochloride (INDERAL®): The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in animal studies at doses about 10 times the maximum recommended human dose.

Hydrochlorothiazide: Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers: Thiazides appear in breast milk. If the use of the drug is deemed essential, the patient should stop nursing.

PRECAUTIONS: Propranolol hydrochloride (INDERAL®): Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause are: dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements such as foods with a high potassium content.

Any chloride deficit is generally mild, and usually does not require specific treatment except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use. If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance. Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

ADVERSE REACTIONS: Propranolol hydrochloride (INDERAL®): Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands; arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to catatonia, visual disturbances, hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Miscellaneous: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

Hydrochlorothiazide: *Gastrointestinal:* anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

Central Nervous System: dizziness, vertigo, paresthesias, headache, xanthopsia.

Hematologic: leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular: orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: purpura, photosensitivity, rash, urticaria, necrotizing angitis (vasculitis, cutaneous vasculitis), fever, respiratory distress including pneumonitis, anaphylactic reactions.

Other: hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

DOSAGE AND ADMINISTRATION: The dosage must be determined by individual titration (see boxed warning).

Hydrochlorothiazide is usually given at a dose of 50 to 100 mg per day. The initial dose of propranolol is 40 mg twice daily and it may be increased gradually until optimum blood pressure control is achieved. The usual effective dose is 160 to 480 mg per day.

One to two IINDERIDE tablets twice daily can be used to administer up to 320 mg of propranolol and 100 mg of hydrochlorothiazide. For doses of propranolol greater than 320 mg, the combination products are not appropriate because their use would lead to an excessive dose of the thiazide component.

When necessary, another antihypertensive agent may be added gradually beginning with 50 percent of the usual recommended starting dose to avoid an excessive fall in blood pressure.

OVERDOSAGE OR EXAGGERATED RESPONSE: The propranolol hydrochloride (INDERAL) component may cause bradycardia, cardiac failure, hypotension, or bronchospasm.

The hydrochlorothiazide component can be expected to cause diuresis. Lethargy of varying degree may appear and may progress to coma within a few hours, with minimal depression of respiration and cardiovascular function, and in the absence of significant serum electrolyte changes or dehydration. The mechanism of central nervous system depression with thiazide overdosage is unknown. Gastrointestinal irritation and hypermotility can occur; temporary elevation of BUN has been reported, and serum electrolyte changes could occur, especially in patients with impairment of renal function.

TREATMENT: The following measures should be employed. **GENERAL:** If ingestion is, or may have been, recent, evacuate gastric contents taking care to prevent pulmonary aspiration. **BRADYCARDIA:** Administer atropine (0.25 to 1.0 mg). If there is no response to vagal blockade, administer isoproterenol cautiously. **CARDIAC FAILURE:** Digitalization and diuretics. **HYPOTENSION:** Vasopressors, e.g., levaterenol or epinephrine. **BRONCHOSPASM:** Administer isoproterenol and aminophylline. **STUPOR OR COMA:** Administer supportive therapy as clinically warranted. **GASTROINTESTINAL EFFECTS:** Though usually of short duration, these may require symptomatic treatment. **ABNORMALITIES IN BUN AND/OR SERUM ELECTROLYTES:** Monitor serum electrolyte levels and renal function; institute supportive measures as required individually to maintain hydration, electrolyte balance, respiration, and cardiovascular-renal function.

HOW SUPPLIED: No. 474—Each IINDERIDE®-40/25 tablet contains 40 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100.

No. 476—Each IINDERIDE®-80/25 tablet contains 80 mg propranolol hydrochloride (INDERAL®) and 25 mg hydrochlorothiazide, in bottles of 100 and 1,000. Also in unit dose package of 100.

References: 1. Veterans Administration Cooperative Study Group on Antihypertensive Agents. JAMA 237:2303 (May 23) 1977. 2. Bravo, E. L., Tarazi, R. C., and Dustan, H. P. N. Engl. J. Med. 292:66 (Jan. 9) 1975. 3. Hollifield, J. W., and Slaton, P. E. Acta Med. Scand. [Suppl.] 647:67, 1981. 4. Holland, O. B., Nixon, J. V., and Kuhnert, L. Am. J. Med. 70:762 (Apr.) 1981.

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Antiques. Killings with Class

cooperate in the bidding) became less effective in controlling the prices, and auction prices began to rival the retail market. In isolated instances, auction prices exceeded "retail." Feeding on such successes, auction houses won consignments that in years past might have been sold to dealers. Naturally, dealers resented the competition but, while they verbalized, "Wish I could get prices like that," they were deciding what of their own stock should go to auction.

Antique shows multiplied until there is hardly a weekend out of the year that a midwestern or eastern collector cannot conveniently get to at least one show. Many dealers closed their shops in favor of traveling several show circuits and today some dealers do 30 or 40 shows a year in as many

different cities.

The young collectors came into the market armed not only with greater knowledge of antiques than many of their forebears, but an appreciation for art which they applied to the field of antiques. 19th century folk art soared

As values rose, antiques literally came out of the woodwork to meet the demand.

in popularity and, along with it, 20th century curiosities. Good weathervanes that pushed \$1,000 at

the beginning of the decade broke \$10,000 by its end. These tyros in the early '70s heard the same comments from long-time dealers wherever they went: "You can't afford to buy anymore," and "the good things aren't around any longer." Undaunted, the new collectors paid the unspeakable prices, watched the prices go higher, borrowed money, paid higher prices, and fueled the inflation of the antiques market of the '70s. And, as values rose, antiques literally came out of the woodwork to meet the demand. Lots of old collections found their way back into the marketplace but many new discoveries were also made. In fact, I believe a thorough study would show that more antiques entered the marketplace for the first time during the '70s than in the previous 30 years.

An American "gate-leg" table of this quality is indeed a rarity and one of this vintage is not native to the Midwest. But the lawyers for the estate of a California collector picked Garth's of Delaware, Ohio above all others to disperse the collection. Albert Sack of Israel Sack, Inc. had to trek all the way out from New York City in May of 1981, to purchase this and several other pieces. While his bid of \$21,000 was probably not a record for this type, it was many times more than what his firm had sold it for years ago. (Photo courtesy of Garth's Auctions, Inc.)



The Sotheby Index

Category	June 8	June 1	Sept 1981	Sept 1980
Old Master Paintings	209	209	199	255
19th Century European Paintings	182	182	176	225
Impressionist & Post-Impressionist Paintings	255	255	239	206
Modern Paintings (1900-1950)	252	252	232	204
American Paintings (1800-pre-WWII)	459	466	424	350
Continental Ceramics	266	266	299	336
Chinese Ceramics	444	445	459	462
English Silver	197	197	160	205
Continental Silver	139	139	143	179
American Furniture	209	209	209	172
French & Continental Furniture	229	229	218	232
English Furniture	271	289	270	256
Weighted Aggregate	253	254	244	253

Sept. 1975 = 100.

* 1982 Sotheby Parke Bernet Inc.

In this week's index, English furniture lost much of the gain recorded earlier in the season. A number of small but potentially significant sales indicated some weakness. They were followed by a larger and very successful sale in London in late May. However, many of the high prices paid at the latest sale were products of the particular circumstances of the event, and therefore are not a reliable indicator of market levels.

In Chinese Ceramics, additional information available from the recent sales in Hong Kong has caused the index to be lowered a further point to 444. A clearer picture of buying patterns also has emerged. Although two important lots went to an American dealer, Far Eastern buyers dominated the sales. Predominant interest was from the Hong Kong buyers, with strong competition from Taiwan, Singapore, and, selectively, from Japan. Contrary to the conventional wisdom that Hong Kong buyers are interested only in fine later porcelains, early ceramics also sold well.

A London sale of Continental ceramics showed values there unchanged. The German market overall appeared weak to steady, with the only strength being seen in the best quality property. This contrasted with the strength recently seen in this area in sales in Continental Europe. Dutch delfware remains consistently weak. French wares are showing signs of strengthening.

There were important broad sales of American paintings at both Christie's and Sotheby's. The market is showing an underlying strength, especially in the Impressionist and 20th Century works, although some minor adjustments to the valuations left the index down 7 points at 459.

Sales of 19th Century European paintings in New York exhibited no particular trend. The market appears to be holding up reasonably well.

The data reflected in the Sotheby Index are based on results of auction sales by affiliated companies of the Sotheby Parke Bernet Group and other information deemed relevant by Sotheby's. Sotheby's does not warrant the accuracy of the data reflected therein. Nothing in any commentary furnished by Sotheby's nor any of the Sotheby's Indices is intended or should be relied upon as investment advice or as a prediction, warranty or guaranty as to future performance or otherwise.

BARRON'S June 28, 1982

Granted, there is more "lower end stuff" than ever before, but I am not certain the percentage of the poorer quality items is any higher.

Was it all uphill during the last decade? Not at all. Like any free market, antiques have their ups, downs, and flats, and the '70s were no exception, but ended on a definite high note. However, the current recession soon began to exert an influence. Probably the greatest single factor in what might charitably be described as a "flat" period in the market is the sustained period of high

interest rates. Young collectors who saw antiques appreciating at rates of 20% to 30% did not think it foolish to borrow at eight to ten percent in order to build their collection or to buy that special item when it was available. Dealers were so little concerned about the interest on their inventory that most who offered a "little time" to clinch the sale never mentioned interest. Show me a collector or dealer today who is unconcerned with interest rates and we will be discussing someone who is either extremely wealthy or who follows the

rule, "Neither a borrower. . ."

Are antiques still a good investment? Certainly! Will we see dramatic changes in the '80s? We already have and there certainly will be more. The greatest uncertainty ahead is the question of interest rates. The high cost of money is a depressant on the antiques and art markets. The prudent, analytical investor shies away from this risky investment, which promises capital gains, in favor of safer, high yield bonds, money markets and certificates of deposit. The young collector knows it is not the time to borrow money to collect. Those with a casual interest who would like to pick up an occasional accent piece for their home cannot justify paying considerably more for the real McCoy; in fact, they cannot justify spending for anything major just now. Whatever the motivation, whatever the category of

You have two chances for success: (1) learn to recognize quality; or (2) establish a relationship with dealers who understand quality.

purchaser, the simple fact is that antiques are in the category of capital goods or capital assets and are affected by recessionary pressures and money rates just as any other capital expenditure. **Except**, antiques are sought after by a small serious core of collectors in bad times as well as good. **Except**, just as some investors buy stocks when the Dow is low, some buy antiques and art during prolonged recessionary periods, banking on a strong emergence. **Except**, the wealthy buy art and antiques regardless of the economy. The common factor in each of these exceptions is quality and the knowledge required to recognize it. Quality always sells more easily, especially in slow periods. With less frantic competition, buyers can and will be more selective. You can be also.

Antiques. Killings with Class

Today can an individual with a moderate professional income afford to invest in or collect antiques? Absolutely! In fact, I know of no better long-term investment medium for the professional, assuming he or she has no aversion to "old stuff." It can be a relaxing hobby that a couple can share. It can furnish your home, or help you do so. It can furnish your office and Uncle Sam will actually help. You can do it at whatever pace is financially comfortable. You can become your own expert or you can purchase the expertise of others. You can build a substantial equity against retirement or a handsome inheritance for your children. If sufficiently adroit, you can experience short-term benefits. You can borrow against your collection for emergencies. You will find it as liquid as your willingness to part with it, and as good an investment as the care (with a measure of good luck) you have taken in making it. With care, there will be no dry holes, no uninsured casualty losses, no drought to worry about, and you will not be able to read about antiques falling 14 points, overnight. Antiques are simply one of the most trouble-free investments going.

But if you are contemplating getting involved with antiques, do not expect to accomplish much unless you are either willing to learn or willing to pay for expertise. Blind guessing does not work over the long haul in the stock market, the race track, real estate, or antiques. You have two chances for success: (1) learn enough to recognize quality; or (2) establish a working relationship with reputable dealers who understand quality. In either case, be willing to pay for quality. It usually costs a little more but produces far better results. With few exceptions, the items which have appreciated most in our collection were the ones for which we paid "beyond the market" because they were quality.

Of course the best approach is to combine both the knowledge and the working relationship. You will have far greater exposure to fine pieces and enjoy them more. Antique dealers, like collectors, come from all walks of life. The dealer-collector relationship has fostered many life-long friendships.

If you can afford to, this is a particularly good time to invest in antiques. Quality pieces are available.

continued on page 575



Above: In June 1980, an American sampler sold at auction for the record price of \$5,750. In January 1981, the Kapnek collection of 172 American samplers sold for \$641,300. The star of the sale was this 1830 work by young Pennsylvanian Matilda Filbert, age 12. The collection was put together by Theodore Kapnek over a considerable number of years, with many individual pieces purchased for "hundreds" rather than "thousands." The quality that went into this collection made it famous and resulted in a new auction record for an American sampler . . . the Filbert work brought \$38,000. (Photo courtesy of Sotheby Parke Bernet.)

Below: While shorebird decoys have attained higher prices, this wood duck drake by Crowell set the record of \$17,050 for a floater at William Doyle Galleries, Inc. in New York City on April 7th of this year. (Photo courtesy of William Doyle Galleries, Inc.)



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1. Promoting Health/Preventing Disease: Objectives for the Nation. U.S. Department of Health and Human Services, November 1980.

*An in vitro simulation of gastric ulcer acid level conditions based on standard laboratory methodology. Data on file. Ayerst Laboratories. Acid-neutralizing capacity of RIOPAN and RIOPAN PLUS = 13.5 mEq/5 ml or tablet.

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It's exciting. It's thrilling. But you have to know what your investment objectives are . . . and you have to know with whom you are dealing.

Gold!

Midas or Madness?

By Joan S. Fulton

The Gold Rush. The Midas Touch. Gold. Man's love and lust for it is like the pursuit of a volatile woman — high risk and not the right investment for everyone.

"It's exciting. It's thrilling. But you have to know what your investment objectives are and you have to know with whom you are dealing." So says W. Arthur "Art" Cullman, Jr., Senior Vice President, Sales, Jackson Precious Metals Co., a subsidiary of Bache Group Inc. Mr. Cullman is also Vice President, Investments, in the Columbus, Ohio office of Bache Halsey Stuart Shields, Inc. brokerage firm.

"When somebody says, 'I want to buy gold,' I always ask about objectives because it makes a big difference what KIND of gold you buy and whether I would even recommend it for you."

Objectives range from wanting to

physically own gold because of fear that the economy will collapse, to wanting to invest in gold for speculation and appreciation. In between there are investors who want to own it because they anticipate new uses for the metal, or they envision a reduction in its supply, or they simply like to wear it and have it for show.

The first objective discussed is the "I want to own it because I think the economy is going to collapse."

Investors with this objective are buying gold as an insurance policy. They take physical delivery of the gold. This gives them a world-recognized negotiable instrument which is immediately available.

"The investor needs to understand that physical possession of a commodity pays no yield. You're losing money if you don't earn a yield. You also have to deal with

transporting and securing the gold. The fact that it is so readily negotiable means it is not identifiable if stolen," Mr. Cullman explained.

"How much of your assets go into this investment depends on how scared you are, but I wouldn't recommend more than 10%. That's just a personal opinion. I would always say it's a high risk investment. Gold's price is extremely volatile. A perfect example is what has happened in the past few years. The price of gold has come from about \$100 an ounce in the third quarter of 1976, to approximately \$850 an ounce at the end of 1979 and early 1980 to April, 1982 where it traded around \$350," Mr. Cullman continued.

Some of the plusses of physically owning gold are: it is a universally accepted medium of exchange; gold coins are less likely to be forged or

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Gold! Midas or Madness?

tampered with than gold in other forms; and it is portable and has a high value per ounce.

Speculation, another investment objective, is the opposite of the "economy is going to collapse" objective. Investors wanting to speculate should look for leveraged situations.

"Leverage has a universal definition of 'using a little to control a lot.' In commodity trading, the use of leverage is called 'margin buying' which is like making a down payment on a house. You use a little money to make a big purchase. The speculator should look for leverage and liquidity. By 'liquidity' I mean the investment should be readily salable. It is for this reason I would not recommend that speculators

The most important thing about speculation is the quick sale. The speculator must be able to get out when he wants.

take physical delivery of the gold. Physical delivery costs more because you must pay for transportation. You must also pay a 'fabrication fee' which is charged to put the gold into the form in which you receive it such as bars or coins like Maple Leafs and Krugerrands," Mr. Cullman explained.

He said the most important thing about speculating is the quick sale. The speculator needs to be able to get out the moment he wants to because of the rapid change in prices. If the speculator has physical possession of the gold, he must ship it to the buyer. Most buyers won't buy it until they have seen it to make sure it is "as advertised."

"I would always recommend that speculators use the commodity exchanges which can be accessed through most major brokerage firms and some specialty commodity houses. By doing this, the buyer is guaranteed a certain contract of gold which sellers all over the world recognize and will

buy back instantly through one of the major exchanges. Trading is done almost exclusively by phone. Therefore, it is easy, quick and available to the investor almost anywhere in the world."

The expense of this kind of trading is relatively modest. For example, the speculator can trade 100 ounces of gold for about \$125 for what is called "a round trip" which is the total expense of buying and selling.

A basic contract bought on the Commodity Exchange (COMEX) is for 100 ounces of gold. The speculator must pay approximately 10% of the cost and is borrowing the balance, at no interest, from the brokerage firm. He is speculating that the price will go up and that he will sell the contract at the higher price.



Art Cullman shows that taking physical possession of gold investments incurs the need to inventory and secure them.

What if it goes down?

"Let's say you bought a contract of 100 ounces at \$400 an ounce. You have put up \$4,000. Now let's say that gold goes down \$100. You would lose \$10,000 (\$100 an ounce times 100 ounces.) Since you have only put up \$4,000 you would, in effect, have lost \$6,000 more than you have invested. When you have lost between 20% and 30% of your equity you are asked to bring it back to the original margin. This is known as a 'margin call.' It doesn't take much to wipe out a 10% margin because the price of commodities is so volatile. The danger of buying on margin is that you are risking a lot more than you are investing," he said.

Emotion is a big part of what affects the commodity markets. According to

Gold! Midas or Madness?

Mr. Cullman, the threat of war will make gold go up almost instantly. Concern about the strength of the dollar is another barometer.

"Right now the dollar is strong and price of gold is down. The average person is more concerned about recession, depression and unemployment than about inflation. It is with inflation, when the value of the dollar goes down, that the price of gold goes up," he explained.

A third reason for buying gold is as an investment. The investor buys it and holds it for an intermediate or long time with the idea that the price will rise again. One of the reasons for that to occur would be high inflation with the weakening of the dollar. Another reason might be a new use for gold which would make it greatly in demand. Other reasons would be a reduction of supply coming from the

reputable source. It is important to be sure that the transaction is legitimate and you receive the gold or have legitimate title to it. If you buy from a reputable source and do not take delivery you have no problem when you want to sell it. The source is buying the same gold he sold you."

Beware of anyone who makes you an offer you can't refuse. The promise of easy money is a number one danger signal.

"The thing I most strongly recommend that you do not do is respond to a long distance call from someone you never heard of, who has a story so great you can't believe it and guarantees you'll make a bundle of money for an investment of a few thousand dollars. That's when you watch out. I can never understand why anyone would send a check to an unknown caller who promises a 'no-risk, can't lose' deal."

Why would anyone?

"Greed, I suppose. The lure of 'get rich' quick. Stay away from cold call solicitors with promises of quick, easy money. That's a danger signal to anyone buying anything."

So, if the gold bug bites — first define your objectives — then find a reputable dealer — but don't put all your nuggets in one pan.

The person who invests in gold is someone who says "Right now there is less inflation . . ."

termination of mining or the withholding of the sale of gold by world governments who are major holders.

Does one take physical possession of the gold with this kind of investment?

"You can go either way. A lot of people like to hold it. I like to hold it. I've got some in my safety deposit box. But don't forget, it doesn't pay a yield, a dividend or any interest. The person who invests in gold is someone who is saying, 'Right now there is less inflation.' I think gold will go back up because people will continue to worry about inflation," he said.

Mr. Cullman has strong feelings about the dos and don'ts when making gold investments.

"The most important first step in investing in precious metal is to make sure it is purchased through or from a reputable source. It might be a brokerage firm, an established coin dealer or a precious metals specialty shop. But you must stick with a

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Joan S. Fulton is a free-lance writer who has been writing for Columbus suburban newspapers for the past 15 years. She currently writes for Suburban News Publications, Inc., a chain of nine weekly newspapers. Mrs. Fulton is a client and long-time friend of W. Arthur Cullman, Jr., and is the widow of OSMA Past President Richard L. Fulton, M.D.

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Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefaclor.

Contraindication: Cefaclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES.

Antibiotics, including Cefaclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Cefaclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefaclor, a false positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistix® tablets but not with Tes-Tape® Glucose Enzymatic Test Strip USP, Lilly.

Usage in Pregnancy: Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in ferrets given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 30).

As with other broad spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Cefaclor.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefaclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefaclor.⁷

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthritis and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefaclor (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain: Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic: Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic: Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal: Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

(1002818)

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Cefaclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

References

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7. Data on file, Eli Lilly and Company.
8. Principles and Practice of Infectious Diseases edited by G.L. Mandell, R.G. Douglas, Jr. and J.E. Bennett, p. 487. New York: John Wiley & Sons, 1979.

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Future Investments



How to assemble a successful retirement portfolio

By Frank E. Pfaff, Esq. and Deborah S. Otte

INVESTMENT STRATEGY - PORTFOLIO CONCEPTS

Are you disappointed with the investment results of your retirement plan investment portfolio? If so, then perhaps you have neglected to adopt a prudent investment strategy.

Careful planning is prerequisite to developing and implementing a successful investment strategy. The important and contrasting characteristics between a qualified retirement plan investment portfolio and a personal investment portfolio must be considered, as highlighted in the following table.

A close examination of the above table strongly suggests that a more conservative and longer-term investment strategy should be employed for the retirement plan portfolio than for the personal portfolio. In working with physician-investors over the past decade, we have developed and have successfully employed an investment concept

IMPORTANT DISTINGUISHING CHARACTERISTICS

Retirement Plan Investment Portfolio

1. The retirement plan portfolio is generally longer-term in nature, with the objective of building asset wealth for retirement, often 20 or more years hence.
2. Liquidity is of primary importance in order to provide funds for retiring or withdrawing participants.
3. Within IRS limitations, cash contributions are tax deductible.
4. Capital gains and dividend/interest income are nontaxable.
5. Tax consequences are generally deferred until retirement or withdrawal.
6. Severe and complex legal restrictions are imposed upon the management and investment of the portfolio by ERISA (Employee Retirement Income Security Act) and other related legislation.

7. The investor may be subject to personal liability by retirement plan participants for mismanagement of fund investments.

Personal Investment Portfolio

1. The personal portfolio is often short-term in nature.
2. Liquidity is often important if the portfolio is created to fund a short-term objective.
3. Cash contributions are not tax deductible.
4. Capital gains and dividend/interest income are fully taxable.
5. Taxes are currently payable.
6. No legal restrictions are imposed upon the management and investment of the portfolio.
7. The investor is not subject to personal liability for mismanagement of portfolio investments.

Future investments

entitled the ***Pyramid Portfolio Program**.[©] Under this concept, a retirement plan investment portfolio is constructed using the same building techniques employed in constructing an actual pyramid. It can be visually demonstrated first by drawing an equilateral triangle (pyramid) and then by dividing it horizontally into three segments so that the heights of the resulting geometric figures are equal. When completed, the investment pyramid/portfolio resembles the following illustration, with each segment encompassing 55%, 33% and 12% of the total area of the pyramid, from bottom to top.

In developing such a pyramid/portfolio, the prospective investor must understand that first laying a solid foundation is crucial to the success of this concept; only after this is accomplished can subsequent vertical segments of the pyramid/portfolio, which entail increasing degrees of risk, be constructed. In addition, each succeeding vertical segment of the pyramid/portfolio, although containing

more risk, encompasses a lesser percentage of the total portfolio than any preceding segment; therefore, any adversity affecting a later segment will have only minimal effect on the total pyramid/portfolio. Unfortunately, many physician-investors have turned this pyramid concept **upside down**: instead of developing a solidly built foundation of superior quality investments, they have first invested in highly speculative securities having commensurately higher degrees of risk. These physicians have failed to separate their own personal investment desires from the more conservative and longer-term philosophy required to manage successfully a retirement plan portfolio. The results can be disastrous.

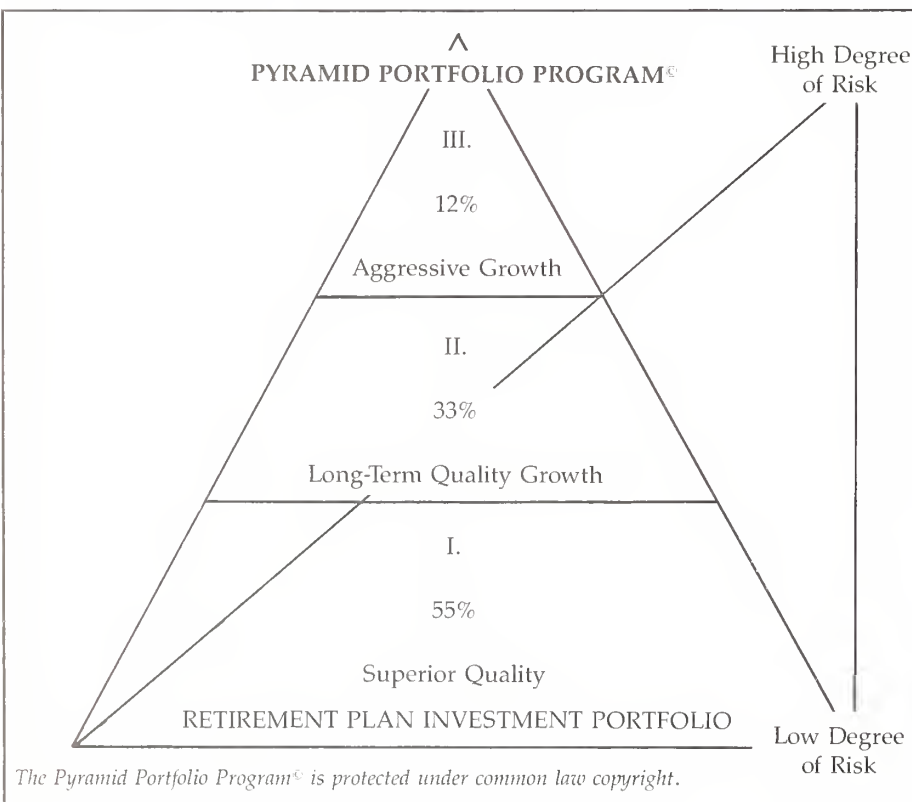
Risks are inherent in the investment markets, but they can be contained and managed; first, by recognizing the risk, and second, by employing counterbalancing measures within a well-structured portfolio. This management is accomplished by the **Pyramid Portfolio Program**.[©]

INVESTMENT STRATEGY RISK

As mentioned above, investments by their very nature are inherently risky. Most investments have two types of risk — market risk and credit risk. Market risk is the risk of loss from market fluctuations, while credit risk refers to the risk of loss arising from the financial misfortunes of the

Risks are inherent in the investment markets, but they can be contained and managed . . .

investee. Usually there is a strong correlation between potential investment return (profitability) and the degree of risk offered by an investment. However, as we shall soon see, in today's unique investment and economic environment, this fundamental rule does not necessarily hold true.



INVESTMENT STRATEGY - BENCHMARK RATE OF INVESTMENT RETURN (PROFITABILITY)

The best benchmark with which to compare potential investment rates of return is 10%, as confirmed through elaborate studies completed at the University of Chicago in 1968 and 1976. These studies show that, over time, random selections of common stocks achieved about a 10% average annual compound rate of return. Interestingly enough, even highly respected and highly paid professional portfolio managers also averaged about this same 10% rate of investment return. Of course, in some years, stock market investments greatly exceeded this 10% investment return benchmark, while in other years common stocks performed well below this standard. Thus, over the long run, both managed and unmanaged common stock investment portfolios averaged about a 10% annual rate of return.

Future investments

INVESTMENT STRATEGY - SPECIFIC INVESTMENTS FOR THE PYRAMID PORTFOLIO PORTFOLIO.©

As illustrated earlier, the three-tiered **Pyramid Portfolio Program**© has the following investment levels. Although these three investment levels may be viewed as separate and distinct, they must, nevertheless, possess a high degree of synergism. It is the responsibility of the investment manager or physician-investor to place appropriate investment vehicles prudently into each investment level. In today's investment and economic environment, we recommend the following investments:

A. TIER I - SUPERIOR QUALITY INVESTMENTS - U.S. TREASURY NOTES

U.S. Treasury Notes are deemed to be the safest investment in the world since they are direct obligations of the Federal Government. Thus, Treasury Notes are free from any credit risk, although they are subject to the usual market risks, as are other fixed income securities (such as corporate bonds). Market risk (volatility) is reduced through careful spacing of maturities over a 5-10 year period. Treasury Notes currently (June 25, 1982) provide nearly a 15% rate of return over any relevant future maturity range, which far exceeds the 10% historical rate of investment return on common stocks. In fact, a recent study by Salomon Brothers, a leading Wall Street investment firm, demonstrated that fixed income securities (U.S. Treasury Notes) outperformed both inflation and any other investment during the 12-month period ending June 1, 1982.

We believe that U.S. Treasury Notes will continue to outperform most other investments over the next 5-10 years and should therefore be included unquestionably in most retirement plan investment portfolios.

B. TIER II - QUALITY GROWTH INVESTMENTS - MUTUAL FUNDS C. TIER III - AGGRESSIVE GROWTH

INVESTMENTS - MUTUAL FUNDS

For both Tier II and Tier III investments, the major investment component should be common stock oriented mutual funds. Although we concluded earlier in this article that U.S. Treasury Notes have superior investment characteristics, prudent investing requires diversification as a counterbalancing measure.

Mutual funds offer several advantages not found in other

methods of investment management. The investment policy and philosophy of each mutual fund are clearly spelled out in its prospectus so that investors can choose funds that fit their own particular investment objectives. Market prices of mutual funds are quoted daily in the *Wall Street Journal* and in the financial pages of most local newspapers. In addition, monthly investment and performance data are provided by numerous advisory services, including Standard & Poor's

Corporation. Comparative mutual fund performance results also are published annually by several leading sources, including *Forbes* magazine. Thus, the comparative performances of mutual funds are widely known, while on the other hand, the performance results of investment funds managed by other types of professional portfolio managers, such as bank trust departments, investment advisors, stockbrokers, and insurance companies, are not readily available and are not presented on a

Steps toward a retirement portfolio.

Tier	Type of Investment	Percentage of Total Portfolio
I	Superior Quality Investments	55%
II	Quality Growth Investments	33%
III	Aggressive Growth Investments	12%
		100%

U.S. Treasury Notes are deemed to be the safest investment in the world, since they are direct obligations of the Federal Government.

comparative basis for review and analysis by investors.

Mutual funds for Tiers II and III of the **Pyramid Portfolio Program**© often can be successfully chosen from the annual *Forbes* magazine "Honor Roll of Mutual Funds," a select list of the 16 best performing mutual funds over the previous decade or so. Approximately 710 mutual funds are surveyed. *Forbes* measures each mutual fund as to its relative performance in both UP and DOWN

markets, and then grades it on an A-F scale. Results of this grading system are extremely important in planning for a retirement plan investment portfolio since the conservative nature of such a portfolio dictates that downside market volatility be reduced to a minimum. Mutual funds should be selected which have demonstrated favorable relative performance in both UP and DOWN markets. Using the **Forbes** "Honor Roll" as the basis for choosing mutual fund investments will offer some protection to retiring or withdrawing participants against adverse market conditions which may prevail at the time they request their vested contributions.

Do not invest in a mutual fund solely because it attained a **Forbes** "Honor Roll" ranking, however. Several of the mutual funds so honored are highly speculative in nature, use leveraged authority (margin), have limited diversification, or employ investment strategy and

techniques not consistent with the **Pyramid Portfolio Program**.© For example, we found only four mutual funds on the latest "Honor Roll" which met our strict requirements for inclusion into a qualified retirement plan investment portfolio. A careful review of the prospectus and descriptive literature offered by a fund is necessary to determine whether or not its investment philosophy is appropriate for a particular situation.

Frank E. Pfaff is an Attorney and Financial/Investment Consultant in Columbus, Ohio. Deborah S. Otte, is associated with Mr. Pfaff and was formerly with a trust department of a major bank.

Meetings

(continued from page 519)

The Physical and Mental Health of Aged Women. October 21-22, 1982; Cleveland, Ohio. The program will feature such nationally known specialists as Robert B. Greenblatt and Carlos Vallbona. Continuing education credits are available. For further information, contact Marie Haug, Director, Center on Aging and Health, Case Western Reserve University, Cleveland, Ohio 44106.

Arrhythmias and Cardiac Ischemia: Diagnosis and Management; October 22-23, 1982; Stouffer's Towers, Cincinnati, Ohio. For further information, contact Mary A. Follenweider, Educational Coordinator, International Medical Education Corporation, 64 Inverness Drive East, Englewood, Colorado 80112.



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Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 3 tablets daily.
AVAILABLE: Bottles of 100, 500.

LIPO-NICIN[®]/100 mg.

Each blue tablet contains:
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Ascorbic Acid 150 mg.
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Riboflavin (B-2) 2 mg.
Pyridoxine HCL (B-6) 10 mg.
DOSE: 1 to 5 tablets daily.
AVAILABLE: Bottles of 100, 500.

Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN[®] 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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"What is a cynic? A man who knows the price of everything and the value of nothing."

Oscar Wilde (1854-1900)

The sale of a medical practice can turn the most reasonable physicians into cynics. Simple formulas cannot accurately determine the price of an established practice. There are many factors to be considered in this complex process. In the end, the price of a medical practice is what a willing buyer will pay a willing seller.

Tangible Assets

It is easiest to determine the value of tangible assets such as the office space, equipment and furnishings, supplies, medications, prepaid expenses, and accounts receivable. Negotiations focus on physical items that are to be converted to a cash price.

A) Office Space

The location, type, and condition of the building are important in determining the price of the office space. The buyer wants to avoid both heavy competition and isolation. Within the physician's suite, the value of such leasehold improvements as dividing walls, plumbing, built-in cabinetry and interior decoration can be negotiated. Their age and condition will influence their price which may range from their present depreciated value to an estimate of their replacement value.

In some cases, leasehold improvements become the property of the landlord and cannot be sold from one tenant to another. Other times the tenant must return the premises to their original condition upon the expiration of the lease. These contingencies should be investigated before the negotiations are completed.

The buyer may be able to assume a

What Is Your Practice Worth?

long-term lease for the office, signed by the seller. The value to the buyer of lower rent payments should be considered in the negotiations.

Quite often, the selling physician owns the building and land, as well. In many cases, it may be advantageous for the seller to keep them as income-producing property. If they are to be sold, the real estate transaction should be completely separate from the sale of the practice.

B) Equipment and Furniture

The seller should develop an item-by-item schedule of equipment and furniture for tax purposes. The price received and the accumulated depreciation of the items will determine if any gain would be taxed as ordinary income and/or capital gains.

An estimate of the fair market value of each item can be obtained by talking with equipment and furniture salesmen. While the seller might view a particular item as being quite serviceable, the buyer might view it as needing replacement. Both the trouble to the seller of disposing of items separately and the cost to the buyer of replacing them will influence each party's negotiating strategy.

C) Supplies, Medications, and Prepaid Expenses

The cost of supplies, medications, and prepaid expenses such as magazine subscriptions and postage are usually negligible relative to the total price of the practice. A detailed physical inventory involves time and expense. To save this, the seller may prorate the total annual supply and medication expenses by an estimate of the number of months' inventory currently in stock. Unopened medications may be able to be returned for credit. The seller should

By Jack Valancy

What is your practice worth?

contact the Drug Enforcement Administration for specific guidance regarding the sale, transfer or disposal of controlled substances.

D) Accounts Receivable

The matter of patient accounts receivable may be resolved in three ways:

- 1) The seller may retain them and continue collection efforts.
- 2) The buyer may liquidate them for the seller. The buyer performs collection activities for a fee, usually a percentage of funds actually collected.
- 3) The buyer may purchase them outright. The price of the accounts receivable may be determined by:

- a) Reducing their face value by eliminating old, presumably uncollectable, accounts.

- b) Multiplying the result by the practice's collection ratio.

- c) Subtracting the anticipated collection expenses.

Intangible Assets

A) Patients

Physician-patient relationships are personal. They cannot be transferred with assurance to another physician. Estimates that attempt to place a monetary value on the strength of such relationships are virtually worthless.

Factors that may appropriately be considered in setting the selling price of the practice include:

- 1) The number of **active** patients or families in the practice.
- 2) The number of **new** patients or families the practice receives each year.
- 3) The **age profile** of the patients in the practice.
- 4) The **types of cases** that are treated in the practice.

B) Patient Records

According to the Current Opinions of the Judicial Council of the American Medical Association, 1981, (7.04): "A physician retiring from practice may not ethically sell his patients' records to another physician. His records have been developed during the physician-patient relationship. To sell records would tend to make the patient

subject to barter to the highest bidder."

Patients should be informed that their medical records will be transferred to their physician of choice upon written request. The physician transferring the records may charge a small fee for secretarial costs.

C) Goodwill

Goodwill is an attempt to determine the value to the buyer of expectations that:

- 1) The selling physician's patients will remain in the practice.

- 2) Referral sources will continue to have confidence in the practice.

The seller may enhance the value of goodwill by introducing the buyer to patients and colleagues in person and in writing. The seller may continue in the practice for a while as a consultant.

The Internal Revenue Service considers goodwill to be a nondepreciable capital asset. To the seller, this means that capital gains tax must be paid on the price received in excess of the amount the seller originally paid for goodwill. To the buyer, tax advantages can be obtained only when goodwill is sold to another buyer. Identifying goodwill as an element of the purchase price could attract close scrutiny by the IRS.

Conclusion

Both tangible and intangible assets help to determine the selling price of a medical practice. To avoid difficulties, both the buying and selling physician should be served by competent legal and tax accounting advisors. Remember, everything is negotiable. "Value is the life-giving power of anything; cost, the quantity of labor required to produce it; price, the quantity of labor which its possessor will take in exchange for it."

-John Ruskin 1819-1900.

Jack Valancy is an independent practice management consultant in Cleveland Heights. He recently completed a chapter on financial management for the forthcoming third edition of **Family Practice**, published by W.B. Saunders Company.



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council proceedings

PROCEEDINGS OF THE COUNCIL

April 30, 1982

A regular meeting of the Council of the Ohio State Medical Association was held Friday, April 30, 1982, at the Stouffer's Plaza Hotel, Dayton.

Those present were: Stewart B. Dunsker, M.D., Cincinnati; C. Douglass Ford, M.D., Toledo; Robert G. Thomas, M.D., Elyria; David A. Barr, M.D., Lima; John E. Albers, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; Alford C. Diller, M.D., Van Wert; Benjamin H. Reed, M.D., Delta; Edward G. Kilroy, M.D., Cleveland; Joseph P. Yut, M.D., Canton; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; A. Burton Payne, M.D., Ironton; D. James Hickson, M.D., Mt. Gilead; S. Baird Pfahl, Jr., M.D., Sandusky; Joseph L. Kloss, M.D., Akron; James E. Pohlman, Esq., Columbus; Oscar W. Clarke, M.D., Gallipolis; William D. Sawyer, M.D., WSU, Dayton; Robert E. Rinderknecht, M.D., Daphne, Alabama; Joseph K. Gilmore, PICO, Pickerington; Jane Lee, Esq., AMA, Chicago; and Shirley C. Davies, President, OSMA Auxiliary, Troy.

Those present from OSMA Staff were: Hart F. Page; Herbert E. Gillen; Jerry J. Campbell; Robert D. Clinger; Katherine E. Wisse; D. Brent Mulgrew; Rebecca J. Doll; Carol W. Mullinax; Robert E. Holcomb; Gail E. Dodson; Eric Burkland; Michael Bateson;

Catherine M. Costello; William E. Fry; and Louis N. Saslaw.

Dr. Dunsker called the meeting to order and introduced Dr. William D. Sawyer, the Dean of the Wright State University School of Medicine.

Dr. Sawyer welcomed the members and guests to Dayton. He spoke of the good relationship of the School of Medicine with the medical community and pointed out that all members of the clinical faculty of the Wright State University School of Medicine are members of the Medical Society Federation.

Dr. Dunsker introduced Dr. Robert E. Rinderknecht, Daphne, Alabama, a former member of the Council, and Jane Lee, Esq., Consultant, Division of Medical Society Relations, American Medical Association.

Group Professional Liability Insurance

Dr. Dunsker reviewed a group professional liability plan proposed by Physicians Insurance Company of Ohio, which was approved in concept at the January 30, 1982 meeting of the Council.

Mr. Gilmore distributed a fact sheet on the plan and discussed details with the Council.

It was the consensus of the Council (concurred in by Mr. Gilmore) that the group policy cover primary coverages only; that premiums be charged at 80% of the current rates; and that it become effective July 1, 1982.

It was the further consensus that the policy be made available only to OSMA members licensed to practice and actively practicing in Ohio who meet the underwriting requirements of PICO.

The Council *approved* the proposal in principle and authorized and instructed the officers to complete the details of the negotiations with PICO and to execute the appropriate agreements implementing the proposal.

Committee on Auditing and Appropriations

Dr. Pfahl presented the minutes of the April 29, 1982 meeting of the Committee on Auditing and Appropriations.

The Committee recommended the adoption of a credit card proposal

involving the Huntington National Bank and employing the use of both VISA and MASTERCARD.

Further, information was provided by Dr. Pfahl and Mr. Campbell with regard to the use of the card to maintain physicians' cash flow through patient payment of accounts with this system.

The Council voted to sponsor the plan.

PICO Building Ownership Plan

A plan involving the OSMA ownership and leaseback of PICO's second building which is to be constructed soon, was presented by Mr. Gilmore and the legal aspects discussed by Mr. Pohlman.

The Council *approved* the plan in principle and authorized and instructed the officers to complete the details of the negotiations with PICO and to execute the appropriate agreements implementing the plan.

Acquisition of Contiguous Property

The Committee recommended the purchase of property contiguous (624 - 630 South High Street) to OSMA's present holdings.

The Council authorized the officers to make the purchase within the financial authority extended to them.

OSMA Building Expansion

The Committee recommended that an architect be consulted with regard to expansion of the OSMA building along lines suggested by the Elford Company of Columbus.

The Council *approved* the recommendation.

Razing of the buildings occupying 634 South High Street, at a cost of \$13,700, was *approved* by the Council, as was the construction of a shower facility in the 600 South High Street building at a cost of \$1500.

The Committee recommended, and the Council *approved*, the purchase of a five-ton Liebert air conditioner for the computer room.

The Council *approved* recommendations from the Committee that OSMA proceed with the mailing list computer file for the Auxiliary at no charge and that OSMA match dollar for dollar, for up to 4500

members, money raised by the Auxiliary through a one dollar dues assessment.

The Council *approved* legal fee reimbursement of \$648.28 to Mahoning County Medical Society.

Financial statements for 622 South High Street, Inc. for 1981 were accepted for information.

The report as a whole *was approved*.

Resolutions

The resolutions before the upcoming meeting of the House of Delegates were discussed, and Councilors were assigned by the President to the three committees on resolutions.

The Council voted to support in principle the concept of a resolution to establish a Resident Physicians' Section of the Ohio State Medical Association. (Dr. Yut dissenting.)

Council Nominees

The Executive Director received

reports from the districts that the following members are candidates for the office of Councilor at the upcoming Annual Meeting:

First District

John E. Albers, M.D., Cincinnati

Third District

Thomas R. Leech, M.D., Lima

Fifth District

Edward G. Kilroy, M.D., Cleveland

Seventh District

H. Judson Reamy, M.D., New Philadelphia

Ninth District

A. Burton Payne, M.D., Ironton

Eleventh District

D. Ross Irons, M.D., Bellevue

Chiropractic Rule

A rule issued by the Ohio Board of Chiropractic Examiners was discussed by Mr. Burkland and Ms. Costello.

They report that the original proposed rule was withdrawn.

PICO Stock

Dr. Ford was authorized to vote the OSMA-owned shares of Class B stock in Physicians Insurance Company of Ohio at the Annual Meeting of PICO shareholders on May 3, 1982.

Dr. Thomas Steps Down

Dr. Dunsker announced that this is Dr. Thomas' last meeting as a member of the Council of OSMA and praised him for his work as a Councilor, as President-Elect, as President and Past President. Dr. Thomas received the applause of the members of the Council and guests.

Dr. Dunsker thanked the Council and the staff for their support and cooperation during his presidency.

There being no further business, the meeting was adjourned.

ATTEST: Hart F. Page, CAE
Executive Director

PROCEEDINGS OF THE COUNCIL

May 3, 1982

A regular meeting of the Council of the Ohio State Medical Association was held Monday, May 3, 1982, at the Stouffer's Plaza Hotel, Dayton.

Those present were: C. Douglass Ford, M.D., Toledo; S. Baird Pfahl, Jr., M.D., Sandusky; Stewart B. Dunsker, M.D., Cincinnati; David A. Barr, M.D., Lima; Herman I. Abromowitz, M.D., Dayton; Thomas R. Leech, M.D., Lima; Benjamin H. Reed, M.D., Delta; Edward G. Kilroy, M.D., Cleveland; Joseph P. Yut, M.D., Canton; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; A. Burton Payne, M.D., Ironton; D. James Hickson, M.D., Mt. Gilead; D. Ross Irons, M.D., Bellevue; Joseph L. Kloss, M.D., Akron; Mrs. Rose Vesper, New Richmond, President, OSMA Auxiliary; Mrs. Shirley Davies, Troy, Immediate Past President, OSMA Auxiliary; Oscar W. Clarke, M.D., Gallipolis; Robert N. Smith, M.D., Toledo; W. Jack Lewis, M.D., Dayton; and James E. Pohlman, Esq., Columbus.

Those present from OSMA Staff

were: Hart F. Page; Herbert E. Gillen; Jerry J. Campbell; Robert D. Clinger; Katherine E. Wisse; D. Brent Mulgrew; Rebecca J. Doll; Carol W. Mullinax; Robert E. Holcomb; Gail E. Dodson; David C. Torrens; Eric Burkland; Michael Bateson; Catherine M. Costello; William E. Fry; and Louis N. Saslaw.

Dr. Ford called the meeting to order.

The President welcomed Drs. Leech and Irons, new Third and Eleventh District Councilors, and Mrs. Rose Vesper, new President of the OSMA Auxiliary.

Committee appointments were presented by President Ford and confirmed by the Council.

A special committee on "Presidents-Elect of Specialty Societies" appointed by President Ford was confirmed by the Council. The purposes of the Committee were prescribed and approved by the Council.

The Council commended the staff on the organization and execution of the Annual Meeting.

The Council *approved* a resolution on closed caption television for introduction at the June meeting of the AMA House of Delegates.

"WHEREAS there are

approximately 200,000 deaf persons and an additional 16,000,000 hearing impaired persons in the United States today, and

WHEREAS these persons are entitled to every opportunity to share as normal a lifestyle as possible, and

WHEREAS closed caption television programs for the deaf and hearing impaired can contribute greatly to the mental health and well being of these individuals, and

WHEREAS closed caption television can help the deaf and hearing impaired improve their speech by allowing them simultaneously to read the words and see them spoken, and

THEREFORE BE IT RESOLVED that the AMA commend NBC for pioneering closed caption programming and encourage NBC to continue such programming, and
BE IT FURTHER RESOLVED that the AMA encourage ABC,



CONTINUING EDUCATION PROGRAMS

PEDIATRICS FOR THE PRACTICING PHYSICIAN: October 1-2; Perrysburg Holiday Inn, Perrysburg; sponsor: Northwest Ohio Pediatric Society and Medical College of Ohio; 12 credit hours; fee: \$150, no charge for residents; contact: James Lustig, M.D., St. Vincent Hospital, 2213 Cherry Street, Toledo 43608, phone: 216/861-6200.

6TH ANNUAL BETHESDA HOSPITAL PHACOEMULSIFICATION, EXTRACAPSULAR CATARACT & IMPLANT SEMINAR: October 1-2; Terrace Hilton Hotel, 15 West 6th Street, Cincinnati; 16 credit hours; sponsor: Bethesda Hospital & Deaconess Association; contact: Thomas J. O'Connor, Bethesda Hospital, 619 Oak Street, Cincinnati 45206, phone: 513/559-6337.

FALL HARVEST OF CME: October 1-3; Sawmill Creek Lodge, Huron, Ohio; 13 mini courses of 5 credit hours each; sponsor: Cleveland Clinic

Educational Foundation; fee: \$60 per course; contact: Director of CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696 or toll free 1-800-762-8172.

CAVITRON PRACTICAL PHACOEMULSIFICATION AND EXTRACAPSULAR LAB: October 3; Terrace Hilton Hotel, Cincinnati; sponsor: Bethesda Hospital & Deaconess Association; 8 credit hours; fee: \$300; Attendance limited to 10 ophthalmologists; contact: Thomas J. O'Connor, Bethesda Hospital, 619 Oak Street, Cincinnati 45206, phone: 513/559-6337 or 6339.

UPDATE IN OBSTETRICS AND GYNECOLOGY — 1982: October 6; Holiday Inn Coliseum, Richfield; sponsor: Northeastern Ohio Universities College of Medicine; cosponsor: Aultman Hospital; 6 credit hours; fee: \$40, \$30 for students or physicians-in-training; Contact: Alvin Langer, M.D., Aultman Hospital, 2600 Sixth St., S.W., Canton 44710, phone: 216/438-6214.

RB&C PEDIATRIC CLINICAL FACULTY ANNUAL SEMINAR: October 7; RB&C Amphitheatre, 2101 Adelbert Road, Cleveland; sponsor: Case Western Reserve University School of Medicine; 7 credit hours; contact: Department of Pediatrics Office, 2101 Adelbert Road, Cleveland 44106, phone: 216/444-1000.

DERMATOPATHOLOGY SELF ASSESSMENT WORKSHOP: October 9; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 6 credit hours; fee: \$100; contact: Director of Continuing Medical Education, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696 or toll free 1-800-762-8172.

1982 INFECTIOUS DISEASE AND IMMUNOLOGY UPDATE: October 13; Imperial House South, West Carrollton, Ohio; sponsor: Wright State University School of Medicine; 7 credit hours; no fee; contact: Mary B. Fisher, Wright State University School of Medicine, Box 927, Dayton 45401, phone: 513/372-7140.

THE SECOND INTERNATIONAL EVOKED POTENTIALS SYMPOSIUM: October 18-20; Stouffer's Inn on the Square, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 18 credit hours; fee: \$350, \$250 for physicians-in-training; contact: Director of Continuing Medical Education, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696 or toll free 1-800-762-8172.

AN UPDATE — THE NEWER CARDIOVASCULAR DRUGS AND THERAPY: October 21; Holiday Inn, Troy; sponsor: Dettmer Hospital; 6 credit hours; fee: \$60, \$30 for nurses and physicians-in-training; contact: Gerard F. Wolf, M.D., 145 Sunset Dr., Piqua 45356, phone: 513/773-8323.

RHEUMATOID ARTHRITIS UPDATE - 1982: October 27, 1982; Daytonian Hotel, Third Street and Ludlow, Dayton; sponsor: Wright State University School of Medicine/Department of Medicine; 6 credit hours; fee: \$90, \$70 for Wright State faculty; contact: Mary B. Fisher, Wright State University School of Medicine, Box 927, Dayton 45401, phone: 513/372-7140.

DIABETES UPDATE - 1982: October 27-28; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$130, \$65 for physicians-in-training; contact: Director of Continuing Medical Education, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5696 or toll free 1-800-762-8172.

CENTRAL OHIO POISON CONFERENCE: October 28; Children's Hospital, Columbus; sponsor: Central Ohio Poison Center; cosponsor: Children's Hospital, Columbus; 8 credit hours; fee: \$50; contact: K. J. Johnson, Children's Hospital, Department of Education, 700 Children's Drive, Columbus 43205, phone: 614/461-2914.

continued on page 578

Obituaries



CHESTER D. BIERY, M.D., Bath; George Washington University School of Medicine, 1947; age 59; died May 29, 1982; member OSMA and AMA.

VICTOR B. HALBERT, M.D., Port Richey, Florida; Physiological Medical College of Indiana, 1908; age 97; died May 26, 1982; member OSMA and AMA.

MOHAMMED A. KHALIL, M.D., Wooster; Gandhi Medical College of Osmania University, Hyderabad Andhra, India, 1962; died May 25, 1982; member OSMA and AMA.

FERNANDO LIM, M.D., Cleveland; College Medical University, Philippines, Manila, 1947; age 60; died May 23, 1982; member OSMA and AMA.

IRWIN McCONNELL, M.D., Toledo; Jefferson Medical College, Thomas Jefferson University, 1934; age 73; died June 4, 1982; member OSMA and AMA.

OWEN McFALL, M.D., Dayton; Meharry Medical College School of Medicine, Nashville, Tennessee, 1921; age 86; died May 12, 1982; member OSMA and AMA.

UMBERT A. MELARAGNO, M.D., Youngstown; Ohio State University College of Medicine, 1932; age 77; died June 15, 1982; member OSMA and AMA.

PAUL P. RINGSMITH, M.D., Kill Devil Hills, North Carolina; Case Western Reserve University School of Medicine, 1947; age 58; died June 5, 1982; member OSMA and AMA.

MORTIMER SIEGEL, M.D., Cleveland; Case Western Reserve University School of Medicine, 1922; age 84; died May 21, 1982; member OSMA and AMA.

ALFRED SILBEGGER, M.D., Pompano Beach, Florida; St. Louis University School of Medicine, 1931; age 75; died June 4, 1982; member OSMA and AMA.

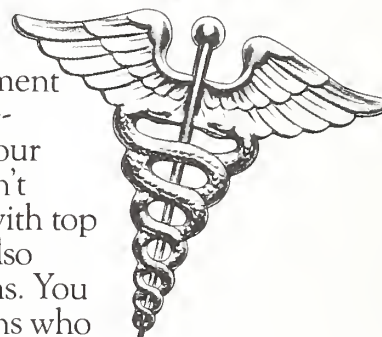
PAUL J. SINGER, M.D., Cincinnati; Loyola University Stritch School of Medicine, 1946; age 61; died May 29, 1982; member OSMA.

JOHN L. WAGNER, M.D., Barberton; Eclectic Medical College of Cincinnati, 1938; age 73; died May 25, 1982; member OSMA and AMA.

FORREST R. YOHE, M.D., Bloomington, Illinois; Loyola University Stritch School of Medicine, Maywood, Illinois, 1926; age 82; died June 9, 1982; member OSMA and AMA.

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Joseph D. Purvis
Martin I. Resnick
Paul C. Venizelos
Eddie Wills, Jr.

DEFIANCE

Herbert Lynn Parsons, Defiance

FAIRFIELD

Prafulla Patel, Lancaster

GALLIA

Lincoln Mario De Souza, Gallipolis

HAMILTON (Cincinnati unless noted)

Stephen A. Estes
Stewart J. Friedman
Cindy S.C. Lee
Douglas K. Logan
Stanley J. Stys
James R. Woods

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Tracy Warren Schermer, Gambier

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Oliver Ralph Roth, Ashland

LORAIN

Michael G. J. Hritz, Fairview Park

LUCAS

Neilma J. Budd, Toledo

MAHONING

Patricia A. Miller, Youngstown

MARION

Charles S. Rothberg, Marion

MONTGOMERY (Dayton unless noted)

- Art Altman, Columbus
Chuck Christopher
Howard Gross
Glenn Hamilton

MUSKINGUM

M. Rajagopalan, Zanesville

ROSS

Bruce E. McNutt, Chillicothe

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The Role of Laser Therapy in the Treatment of Senile Macular Degeneration: Current Status

By Robert A. Bruce, Jr., M.D. and Frederick H. Davidorf, M.D.

Editor's Note:

The intent of this manuscript is to help patients and physicians understand the role of "Laser Therapy" and its limitations in ophthalmological medicine.

INTRODUCTION

In May of this year, the national news media reported the early results of a National Institute of Health (NIH) study on the benefits of laser photocoagulation in the treatment of senile macular degeneration (SMD). Since the release of this information, thousands of people afflicted with this blinding eye disease have sought aid and advice from those in the medical profession. Certainly many of these patients should be evaluated for possible laser therapy; however, many patients who already have been devastated visually by this process have had their hopes raised only to be disappointed by the lack of applicability of the treatment to their stage of the disease. In this article, a discussion of a pathophysiology, natural history and classification of macular degeneration is offered. Additionally, the criteria for laser treatment according to the NIH study will be enumerated as will a set of guidelines that the nonophthalmologist may use to guide

referral of his patients for evaluation for laser therapy.

SMD is a heredodegenerative disease of the macular area of the retina and is a leading cause of legal blindness in the elderly. More than 10 million people over the age of 50 are affected to some degree by SMD.¹

PATHOPHYSIOLOGY

As stated, SMD only affects the macular area of the retina. The macula is an area approximately 1.5 to 2 mm in diameter located several millimeters temporal to the optic nerve. This area of the retina provides central vision, ie, reading vision. The macula is composed exclusively of photoreceptors known as cones. The cone is the most sensitive of the two types of photoreceptors, the other being the rods, which function in dimly lit situations such as night vision. The cones also allow for the perception of colors. As one moves away from the macular area of the retina, the concentration of cones decreases rapidly while the concentration of rods increases dramatically. Therefore, the visual acuity or sensitivity of the retina to color and fine detail decreases as we move away from the macula.

SMD is a vascular disorder resulting

in a secondary disruption in the photoreceptors and pigment epithelium of the retina. The pigment epithelium provides a metabolic support for the photoreceptors, and its basement layer, Bruch's membrane, serves as a barrier between the retina and choriocapillaris, a capillary network of the choroid. Macular degeneration results from a loss of the integrity of Bruch's membrane that allows fluid, blood, and new vessels to pass into the subretinal space. This disrupts the photoreceptors, causing visual impairment.

NATURAL HISTORY

SMD is initiated by the development of drusen, yellow round deposits deep within the retina. Histologically, drusen are excrescences on Bruch's membrane. Development of drusen is followed by deterioration of the competency of Bruch's membrane, allowing leakage of fluid from the choriocapillaris or actual growth of new blood vessels into the subretinal pigment epithelium or subretinal spaces. These new vessels leak fluid or rupture, resulting in hemorrhage into the subretinal space. This causes diminished function to the cones. The final sequelae to the changes may be

scar formation in the macular area, eliminating macular function altogether.

CLASSIFICATION

SMD is an asymmetrical bilateral disease, usually affecting patients 50 years of age or older. The symptoms vary widely as does the rapidity of progression. Davidorf² has classified SMD functionally into the following categories: (1) no/minimal involvement (visual acuity: 20/20-20/40); (2) mild involvement (visual acuity: 20/50-20/100); (3) moderate involvement (visual acuity: 20/100-20/400); and (4) severe involvement (visual acuity: less than 20/400).

In the first category, patients will experience little if any visual symptoms. Usually any blurred vision at this stage can be corrected with spectacles. Examination of the retina usually will reveal a loss of the normal foveal light reflex, mottling or mild disruption of pigment, and drusen. The recognition of these changes should be noted, and the patient should be followed on an annual basis if vision remains stable and at shorter intervals if vision decreases.

Patients in the second category usually will complain of blurred reading vision, which is aided only slightly by spectacles. They also may report distortion of vision when looking at light posts, telephone poles, or the painted lines on the road (Fig 1). Clinical examination reveals drusen or mild accumulation of fluid under the retina, which is the histopathologic manifestation of the visual symptoms (Fig 2). At this stage, the amount of fluid in the subretinal space is very small. Fluorescein angiography at this stage does demonstrate one or more breaks in Bruch's membrane.

The category of moderate involvement is characterized by a worsening of the above symptoms. These patients will be unable to read virtually all but the largest print (Fig 3). Any daily activity that requires acute vision becomes burdensome. Clinical examination reveals significant disruption of the RPE with elevation of the retina, demonstrated either by a yellowish or dark discoloration caused by the chronic presence of fluid in the

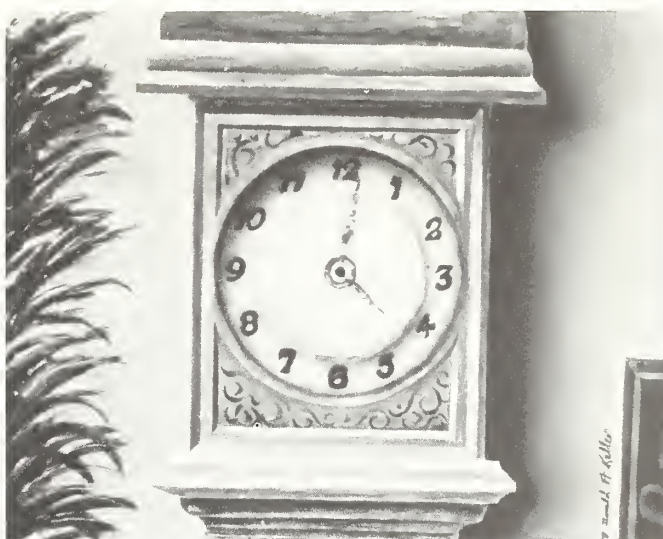


Figure 1: The patient's visual perspective in the second category of SMD.



Figure 2: Clinical manifestation of the second category reveals drusen or mild accumulation of fluid under the retina.

subretinal space or the presence of hemorrhage in the subretinal area (Fig 4). Histopathology of this stage shows the growth of a neovascular membrane into the subretinal space through breaks in Bruch's membrane.

The fourth category of severe involvement is manifested by an almost complete loss of macular function and, symptomatically, a central blind spot (scotoma) in the center of the field of vision (Fig 5). The onset of this stage is usually rapid,

secondary to the occurrence of a large or dense hemorrhage in the subretinal space of the macula (Fig 6). Almost invariably, as the hemorrhage is evacuated by the body's clean-up mechanism, a large fibrovascular scar is left (Fig 7). This results in a permanent loss of macular function.

The time sequence of these various stages of development of SMD varies from patient to patient. As mentioned earlier, this disease process is bilateral but asymmetrical in its involvement of



Figure 3: The patient's visual perspective in the third category of SMD.



Figure 4: Clinical manifestation of the third category is characterized by significant disruption of the RPE with elevation of the retina, demonstrated by a yellowish or dark discoloration.



Figure 5: The patient's visual perspective in the fourth category.

the two eyes. There may be many years' difference in the onset of symptoms; however, eventually both eyes are involved equally.

MANAGEMENT

In the past, the treatment of the SMD patient has included a complete eye examination consisting of the following: refraction for best vision, dilated fundus examination, slit lamp examination with measurement of intraocular pressure, fundus photography, and fluorescein angiography to evaluate the status of Bruch's membrane and the presence or absence of subretinal neovascularization. Laser treatment has been used in a very small percentage of patients for the last 10 to 15 years to destroy the subretinal neovascular membrane and prevent hemorrhage, thus stabilizing visual acuity. In most cases, however, laser therapy is not effective. Therefore, the primary role of the ophthalmologist is to provide psychological support by emphasizing that although central vision is destroyed, the majority of patients maintain their peripheral vision, and with some adjustment, most maintain a great deal of their visual independence.

Three years ago, a controlled study was initiated to try to identify whether or not laser therapy of the subretinal neovascularization was of value in the stabilization of SMD. In May, 1982, after three years of a five-year study, the investigators believed that a significant pattern already had developed in the treated versus nontreated groups. The study revealed that 60% of untreated eyes lost the majority of their central vision, while only 25% of the treated group showed serious visual loss.³ Release of this information to the national media has resulted in physicians in all fields of medicine being overwhelmed by inquiries from patients who either have been diagnosed as having SMD or by patients who believe that they may have the disease. These individuals often are disappointed to learn that the treatability of a particular patient depends on the location of the subretinal neovascular membrane. If the subretinal neovascularization lies outside the

capillary free zone of the macula, argon laser photocoagulation is recommended. If, however, the neovascularization lies inside the capillary free zone, laser therapy cannot be performed because treatment to this area will cause irreparable damage to the retina. In this situation, laser therapy makes the vision worse, and its use, therefore, is discouraged. In addition, laser therapy also is not indicated in those patients whose disease has progressed to the fourth category of involvement characterized by the presence of scar formation.

The criteria for inclusion for treatment in the recent NIH study are as follows: (1) drusen; (2) angiographic evidence of choroidal neovascular membrane at a distance of 200 to 2,500 microns from the center of the foveal avascular zone; (3) best corrected visual acuity of 20/100 or better; (4) symptoms related to neovascular membrane, eg, decreased acuity, Amsler grid distortion, metamorphopsia, or uniocular diplopia; (5) no prior photocoagulation in the study eye; (6) no other ocular disease that could affect independently the visual acuity; (7) patient age of at least 50 years; and (8) informed patient consent.³

To aid the nonophthalmologist in advising patients who may have or believe they may have SMD and who wish evaluation for possible laser therapy, the following guidelines can be employed:

1. Visual acuity of at least 20/100 to 20/300 with best correction. This should be a distance measurement at 20 feet or its equivalent. This measurement can be performed with ease in any medical office with the standard Snellen chart. A greater variance of visual acuity than is outlined in the NIH study is acceptable because many patients can be improved to at least the 20/100 level with refraction, which is routinely available only in an ophthalmologist's office.

2. Blurred or distorted central vision as reported by the patient. Metamorphopsia or distorted central vision is best evaluated with an Amsler grid. This grid consists of a piece of graph paper with a large or

dark central spot for visual fixation. The patient is asked to cover one eye and, with the uncovered eye, to stare at the fixation point. A description of the appearance of the lines on the graph paper then is elicited from the patient. The patient may describe a waviness of the graph lines or a haziness of a specific area of the graph lines around or even involving the fixation point. The presence of an abnormal response in either eye is justification for ophthalmic evaluation.

3. The subjective complaint of uniocular (monocular) diplopia or double vision. Diplopia usually results from a misalignment of the two eyes for one of many well-known reasons. Monocular diplopia, on the other

hand, is caused by only a very few entities. These include a corneal scar resulting in distortion of part of the corneal surface, a double focus cataractous lens/vitreous opacification, and a localized elevation of the retina involving part of the macular area. Patients with monocular diplopia should be referred to the ophthalmologist.

4. The recognition of drusen or pigment disruption in the area of the macula on dilated fundus examination. This can be accomplished easily in any physician's office with the instillation of 2 1/2% neosinephrine drops in the patient's eyes. This is an efficient and rapid way to obtain dilatation of the pupil for evaluation of the posterior



Figure 6: Clinically, the fourth category is characterized by a large, dense hemorrhage in the subretinal space of the macula.



Figure 7: After the hemorrhage is evacuated, a large fibrovascular scar is left, resulting in a permanent loss of macular function.

pole of the globe. The side effects from this drug are minimal, ie, persistent dilatation causing light sensitivity for four to six weeks. It is not associated with the cardiac side effects that have been documented with 10% neosinephrine solutions.

The recognition of any one of these symptoms by the nonophthalmologist should be a basis for ophthalmological evaluation of the SMD patient. Further evaluation for laser therapy must include fluorescein angiography, which will outline precisely the extent of the retinal process and indicate whether or not the lesion is amenable

to laser therapy.

SUMMARY

SMD is a major health problem in the elderly. It affects more than 10 million individuals over the age of 50 and is the leading cause of blindness in the elderly. Despite the recent reports involving the effectiveness of laser therapy for SMD, the vast majority of patients still have untreatable lesions or scars for which no therapy is available. The current NIH study confirms only that in a very small percentage of patients laser therapy is, in the short term, an

effective means to retard visual loss.

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How to talk like an investor . . .
(continued)

primary market

Market for new issues of municipal bonds.

refunding

The redemption of a bond issue by the sale of a new bond issue, usually at terms more favorable to the issuer.

registered bond

A bond whose owner's name is registered with the issuer or its agent.

revenue bonds

Bonds payable from and secured by stated revenues from a specific project or group of projects.

secondary market

A trading market in which previously issued bonds are bought and sold.

sinking fund

Money set aside by the issuer to be used to retire the issue.

syndicate

A group of investment bankers and/or banks who underwrite a municipal bond issue and offer it for public sale.

term bond

A bond which has a single maturity.

underwrite

To purchase a bond issue from the issuing body for the purpose of reselling it to the general public.

yield to maturity

The average annual return on an investment, based on the amount paid, the interest rate, and the length of time to maturity. It differs from current yield in that it takes into consideration the increase to par of a bond bought at a discount and the decrease to par of a bond bought at a premium.

Real Estate Investing: Returns to the Land (continued)

Earlier, I described the role of the Certified Property Manager. There are members of the American Institute of Real Estate Counselors who advise on a program of investment, giving third-party advice for a professional service fee, not a commission on the transaction. Members of the American Institute of Real Estate Appraisers specialize in making professional evaluations on real estate.

When it comes time, for whatever reason, to either trade your real estate or obtain further investments, then you can rely on the REALTOR who is a broker and specializes in buying and selling real estate.

My personal advice to the person with capital to invest and limited knowledge about investment opportunities in today's economic logjam is to run, don't walk, to the professional counselor who can spell out the pros and cons of real estate investment.

Richard L. Royer is President of the Ohio Association of Realtors, and is a principal of Kohr and Royer, a Columbus commercial-investment real estate firm. He has been involved in real estate since 1958, and has been active especially in the areas of appraisal, investment counseling, brokerage, and property management.

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Antiques. Killings with Class

(continued from pg. 543)



The Shakers were an American religious sect with strict communal rules, among which were vows of celibacy. While men and women belonged, they obviously depended on converts for continuance. At their height in the middle of the 19th century, their craftsmen took pride in their work, producing items for their own use, as well as for commerce with "the World." Always prized for their simplicity, functionality, and durability, Shaker pieces have risen dramatically in value over the last decade. The case of drawers shown here was made in Enfield, Connecticut, and recently sold for the first time for \$34,100 at Pioneer Auctions in West Brookfield, Massachusetts. (Photo courtesy of Ohio Antique Review.)

The competition is relatively low. Dealers have time to spend with customers and, in many instances, will make price concessions in order to help their cash flow. Auctions and shows abound in the spring and autumn in the Midwest but taper off in the summer. In New England, they are abundant in the summer, but be aware that they are geared to the tourist traffic, not serious collectors. Subscribe to one or more of the trade periodicals; you will learn quickly what's happening and where and be able to keep up to date on prices.

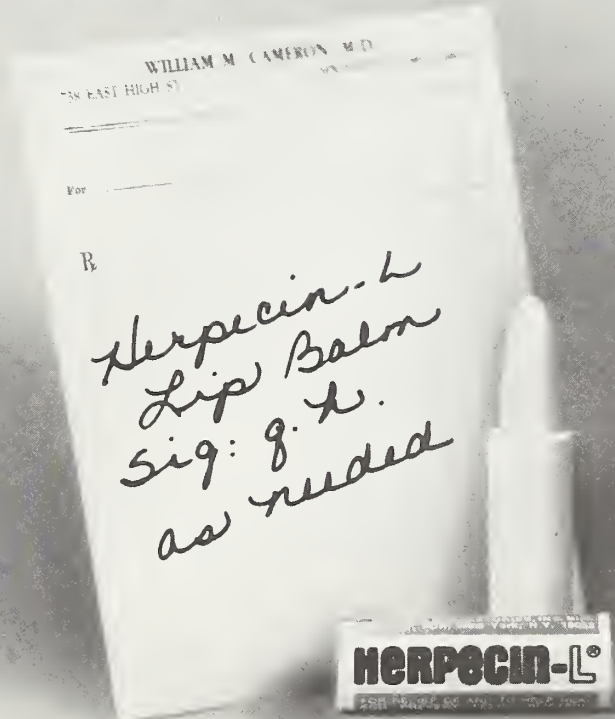
If you are curious about investing in art and antiques but do not want to risk serious dollars at it, try another

tack for fun and profit. Spend some time at the shows and auctions and with the trade publications. Then put your knowledge to the test at flea markets and garage sales. You will be amazed! There are dealers and pickers who make a living this way!

A word of caution. Investing in antiques may lead to collecting. And collecting antiques can become an all-encompassing passion that can seriously interfere with your hunting and fishing, not to mention the devastating effect it can have on your golf or tennis game. I speak from experience.

James T. Lowder is president of Abrasive Technology, Inc., and publisher of **Ohio Antique Review**, with editorial offices in Worthington, Ohio.

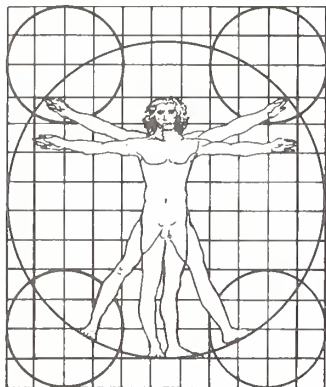
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CLINICAL & SCIENTIFIC

THE STATE OF THE ART OF LASER MEDICINE Leon Goldman, M.D.

In recent years, there has been rapid growth of laser medicine throughout the world, as an accompaniment of the extraordinary developments of laser technology. It now is necessary to open up lines of communication to physicians. Properly informed, they can evaluate the current uses and limitations of laser medicine. Laser medicine includes instrumentation for clinical and laboratory diagnosis, especially for current studies of immunology, investigative studies for the treatment of some forms of arthritis, and mostly in uncontrolled studies, for the treatment of chronic ulcers, viral infections and chronic infections. There now are laser surgical instruments for every area of surgery. With planned programs of laser safety, laser treatments are safe for the patient and the operator. Laser medical research and development, developed originally in the United States, is now more extensive in Europe, China and Japan. This is true also for laser dentistry. Laser veterinary medicine is being developed in the United States, but has been used for some time in China and Japan.

WITH THE RAPID DEVELOPMENT of laser medicine since 1961,¹⁻³ it is well to review critically the current state of the art so that physicians can be aware of the indications and lack of indications for the use of lasers in clinical studies for diagnoses and treatment. In our laboratory, there was a sign: "If you don't need the laser, don't use it." With knowledge, a physician can give advice, especially to those patients who read newspaper headlines.

The laser is simply a very strong light. "Laser" is an acronym: Light Amplification by Stimulated Emission of Radiation. Many physicians are not aware that this special form of light has excellent properties which make it useful in medicine. It is monochromatic; it can be used for definite, specific indications; it is coherent, so it has a uniform wave pattern; it is collimated so it can be very precise with little divergence of the light beam; it can be made as powerful as one desires; it is superior for hemostasis. Its optical knife, as it were, does not come in contact directly with the tissues. This is excellent, especially for vascular surgery, and also has made it possible to cut radioactive materials without so-called "contamination" of the knife. There are many different lasers, as there are many different areas of the electromagnetic spectrum. Lasers in the visible light range are absorbed more by pigments in tissue —

pigments either natural or induced. These characteristics have made for a new modality for therapy in medicine. There has been rapid progress, as indicated, in laser medicine and surgery. In 1982, the laser market in the free world was \$1.51 billion. The percentage of the military application was 54%. The market for laser medicine and surgery was \$51 million with 30% annual increase.

As evidence of the ever-increasing interest in laser technology, there is the American Society of Laser Medicine and Surgery, organized recently and with over 200 charter members, with specific sections on laser biophysics, laser chemistry, laser safety, laser biology, laser biomedical engineering, laser medicine, and different sections on laser surgery, general surgery, head and neck, plastic, eye, gynecologic, gynecologic oncology, rectal, endoscopy, neurosurgery, urology, dermatology and orthopedics. The author is the retiring president of this society. In the United States there is a very active Laser Gynecologic Surgery Society with 200 members and a detailed tumor registry. There was an International Society of Laser Surgery, which met in Japan in November 1981, with a registration of 1,300 and 300 papers. There are local laser medical societies. The Laser Medical Society in Japan has a membership of 400. The Laser Medical Society in Shanghai, China has a membership of 400. There are special laser medical societies in Israel, Italy, France and more societies are developing in many other countries. An International Confederation of laser societies, the International Confederation Laser Advisory Council for Laser Medicine, has been proposed recently by Atsumi⁴ of Japan, of which the author is president. There is an increasing awareness and interest in laser medicine by laser manufacturers.

The current lasers used in medicine comprise different lasers. In some, the impact of the laser can be continuous (CW) (this is preferred for surgery), or the impacts can be pulsed in milliseconds or in picoseconds. The medical instruments are (1) argon laser, continuous wave, blue-green; (2) carbon diox-

Dr. Goldman, Cincinnati, Professor Emeritus Dermatology and Former Director, Laser Laboratory, University of Cincinnati College of Medicine; and Director, Laser Treatment Center and Director Laser Research Laboratory, Jewish Hospital, Cincinnati, Ohio.

Submitted May 18, 1981.

ide laser, the old system and recent sealed tube RF wave guide, in the far infrared, continuous wave, invisible; (3) Neodymium Yttrium Aluminum, garnet (Nd YAG), near infrared; and (4) helium-neon laser, red, continuous wave.

There is current research in the development of a Neodymium Yttrium Perovskite (Nd YAP). This is being studied in Germany so that the duration of this laser is in one-thousandth of a second, so there will be less heat developed and less heat radiation and transmission spread to adjacent noninvolved tissues.

The laser reaction in tissues is similar to that of an electric burn. There is no recorded evidence of any carcinogenic activity in thousands of patients treated with the laser since 1962.^{1,2} The initial treatments were given in the eye. If new lasers in the ultraviolet area are used more frequently in clinical medicine, and lasers developed in the x-ray region are used, it will be necessary to conduct studies regarding their immediate and long-term carcinogenic potential. There has been no evidence of cancer as a result of the application of lasers in clinical medicine and surgery.

The laser is a strong light, therefore, safety programs are necessary regarding the laser itself and the area in which it is used, special protective eyeglasses for each laser type used, and protection of the skin. In industry, material processing of the laser may give rise to pollution of the air. In brief, it may be said that with planned programs of laser surgery as to the instrument, area, patient and operator, the laser is safe to use for patient as well as operator.

The basic field of current laser research is in laser biology. Two great programs at present are Laser Microbeam Program (LAMP) at the University of California at Irvine, under the direction of Michael W. Berns,⁵ and the program in biological research at Laser Energetics in Rochester, New York. These laboratories are available to show their specific goals for the future.

Another development of laser microbeam irradiation is flow cytofluorometry. This has made it possible, after developments at the Biological Laboratories at Los Alamos, to do massive scanning of Pap smears, for study of DNA, RNA, and the study of cytogenetics in leukemia, and also for the use of the laser in cell sorter systems for the current developments of the hydridoma technology. Hybrid cells are produced by crossing a normal cell with antibody production, with cancer cells of an animal which can produce such cells rapidly. As a result, there is the rapid practical production of monoclonal antibodies for diagnosis and hopefully, for therapy. There is also the relation of this form of laser medical technology to the current programs of gene mapping and gene "molecular engineering." Particle size measurement by the lasers has also made it possible to develop laboratory instrumentation, including the laser nephelometer for the estimation of immunoglobulins, and rheumatoid factors in the blood.

Various analytical spectroscopic technics with the laser, originally developed for industry, are used now in Germany for the estimation of electrolytes, alcohol in the blood,⁶ and in this country, the detection of carcinogenic materials in the atmosphere. Laser-induced fluorescence is used for the detection of drugs, and now for the early diagnosis and treatment of cancer of the lung, stomach, colon, bladder and skin. Another development in the field of laser medicine, included as a clinical application of laser immunology, is the laser-controlled treatment of some types of rheumatoid arthritis, according to Goldman.⁷ Helium-neon, helium cadmium and krypton lasers now are used in low output systems, in Germany as immunosuppressives and immunostimulating agents, for the treatment of chronic infections, and for chronic leg ulcers in accessible areas. The author and his colleagues have used, with improvement, helium-neon laser irradiation, also in uncontrolled studies for the treatment of the ulcers of necrotizing vasculitis of lupus erythematosus. The laser treatment for arthritis is to be opened shortly in the Laser Treat-

ment Center at the Jewish Hospital in Cincinnati. This same group has also treated with the helium-neon, HSVH Type 2 lumbosacral lesions. This did not prevent recurrences. All studies for laser stimulation and laser immunosuppressive effect require more controls. The current applications on face lifting and rejuvenation of the skin by helium-neon lasers are without value, and even though of low output, under some circumstances may be hazardous to the eyes.

Laser transillumination, passage of light through tissue, is being studied by the author and his associates at the present time with low output laser beams, of various lasers in an attempt to diagnose carcinoma of the breast in its early stages. Current laser imagery is far inferior to those produced by the more hazardous applications of x-rays, mammography and xerography.

Laser acupuncture, as a control to other types of acupuncture, is used in China, Japan, Germany and the USSR, in man and in animals, with increasing laboratory studies of endorphins and Naloxone suppression. Laser acupuncture for anesthesia and analgesia is used extensively in veterinary medicine in the United States and in other countries.

The multidiscipline applications of laser surgery started with laser treatment of eye disorders because of the hazard of laser light transmission by the lens of the eye, producing burns on the retina. Red ruby lasers with millisecond impacts first were used for welding the retinal detachments. Lasers for eye surgery are available in most medical centers and in offices of ophthalmologists for the treatment of retinal neovascularization in diabetes, hemorrhages in the eyes, senile macular atrophy, tumors, and treatment of glaucoma. There is increasing interest in research and development for the laser as a diagnostic instrument in ophthalmology.⁸ A recent development is the use of special YAG and Neodymium YAG Lasers for cataract operations.

There also have been extensive programs in laser cancer research. These continue from the early investigations of microirradiation of cells and tissues. The early laser surgery was for cancer, especially melanomas and other tumors. Because of the selective absorption of lasers in the visible light range for pigmented tissues, lessened bleeding, and precise surgery, frequent use has been made of the laser for cancer surgery, alone as a curative agent, as well as an adjuvant for the palliative treatment of inoperable cancer. The most important area in the laser cancer program, however, has been in laser gynecologic oncology for laser with a microscope, colposcopy, for the treatment of cervical (CIN) and vaginal intraepithelial neoplasia (VIN) with curative laser treatment. Laser surgical treatments are used also in neurosurgery, rectal surgery, head and neck surgery, especially for laryngeal lesions, laser endoscopy for gastric bleeding, and laser cystoscopy in urology, plastic and dermatologic surgery for incurable portwine marks and tattoos, etc. Advances in laser surgery have made it possible for the various surgical specialties to indicate those conditions which are obligatory for laser surgery, those which are preferred for laser surgery, and finally, those where the laser is not needed. Extensive literature is available on laser surgery.⁹⁻¹⁸

A question being considered at present is how and where does one learn laser surgery. The basic axiom is that in order to practice effective laser medicine, one must be expert in his particular field, and be trained in laser technology. As Ascher¹⁶ says in regard to laser neurosurgery, "There are no good or bad laser surgical instruments — there are only good or bad operators." The American Society of Laser Medicine and Surgery is attempting to standardize effective courses in various phases of laser medicine. The Laser Gynecological Society also is developing standard approved courses for laser gynecologic surgery. We are preparing in Cincinnati for our third, certified "on hands" laser surgery course in 1983. This will be for dermatology and plastic surgery and will be conducted by Dr.

Richard O'Gregory and the author.

With the help of the Medical Instrument Division of the BRH of the FDA and the specialty societies, an attempt is being made also to produce qualified laser operators, as well as critical evaluation of the performance standards and safety of laser medical instrumentation.

A recent experiment in this field of teaching laser medicine was the development of the laser teaching program for the entire staff at the Jewish Hospital Medical Center in Cincinnati. The program was given by laser expertise, of the Medical Center of the University of Cincinnati. The entire staff of the Jewish Hospital, family practitioners, pediatricians, internists, laboratory personnel, nurses, pathologists, as well as all surgeons, were included. The course included backgrounds of laser physics, laser technology and instrumentation, laser safety, applications in general medicine, laboratory and surgery. For the surgeons, a practical examination on meat cutting was done in the operating room regarding laser safety, excisional and photocoagulation laser surgery. This preceded an apprentice association program with the laser expertise on the staff. The laser medical expertise from the College of Medicine and the Jewish Hospital of Cincinnati have cooperated in two seminars, to date, on a "hands on" teaching program for laser surgery.

Other laser medical centers have given specific programs, usually in surgery, and have accepted visits and even OR instruction. Definite certificates for training in ophthalmology were given for the ophthalmologist in California so they could do laser eye surgery in their respective hospitals. Similar certificates are given in our surgery courses.

It is evident that there is increasing progress in laser medicine. It is obvious also that this colorful instrumentation has an attractive gadgetry appeal and the sign should be, as it is in our own laboratory, "If you don't need the laser, don't use it."

There is increasing interest in Congress to develop a national laser institute. It is not evident whether this will be for industry or for the military and not for medicine. Previous unsuccessful attempts were made recently and in the past to develop, similar to x-ray radiation institutes, a National Biomedical Laser Institute with clinical facilities for the critical evaluation of biomedical laser research, development of laser safety programs and laser applications in medicine and surgery for outpatient and inpatient clinical research. This is still the goal for the future. The other goal is the International Confederation of Laser Advisory Council for Laser Medicine.

The physician, as indicated repeatedly, must be aware of these important current developments in laser biology, laser medicine and surgery, laser technology as a whole such as

laser nuclear fusion, spin-offs for laser medicine, the great revolutions in laser communication and information handling, deliverance of better health care to patients, and better learning programs of medicine by medical, nursing, and paramedical personnel. The laser is producing a great deal for the good of man and can do even more for the future.

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Continuing Education (continued)

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1982 KIDNEY DISEASE UPDATE:

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Council Proceedings (continued)

CBS, PBS and the cable networks to follow NBC's lead and begin to or continue to offer closed caption programming."

There being no further business, the meeting was adjourned.

ATTEST: Hart F. Page, CAE
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Hepatitis B and Liver Cancer

As evidence linking hepatitis B virus to liver cancer continues to mount, the use of the newly licensed vaccine against the virus is being seen as a possible way to protect against this single form of cancer, says Harvey J. Alter, M.D., in a recent issue of the *Journal of the American Medical Association*.

Dr. Alter, who is chief of the immunology section at the National Institutes of Health Clinical Center Blood Bank Department, foresees the possibility that hepatitis B vaccine may become, at least indirectly, the first cancer vaccine by conferring protection against the hepatitis B virus, thereby breaking the chain of events that is thought to lead to liver cancer in some people.

Hepatitis B vaccine, which is due later this year, is expected to decrease the incidence of hepatitis B infection and reduce the number of hepatitis B carriers, who are at high risk for developing liver cancer.

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Contraindications: Known hypersensitivity to drug.

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) reported after abrupt cessation of extended use of excessive doses are similar to those seen with barbiturates. Milder symptoms reported infrequently when continuous therapy is abruptly ended. Avoid abrupt discontinuation; gradually taper dosage.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship has not been established clinically. Due to isolated reports of exacerbation, use with caution in patients with porphyria.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally observed at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction, changes in EEG patterns (low-voltage fast activity) may appear during and after treatment, blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral—Adults:* Mild and moderate anxiety disorders and symptoms, 5 or 10 mg *t.i.d.* or *q.i.d.*; severe states, 20 or 25 mg *t.i.d.* or *q.i.d.* *Geriatric patients:* 5 mg *b.i.d.* to *q.i.d.* (See Precautions.)

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600 South High Street
Columbus, Ohio 43215
Telephone: 614/228-6971

Address All Correspondence, Address Change, & Reprint Request (unless otherwise noted): Executive Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215. Phone: 614/228-6971.

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1981 Subscription: \$15 per year, single copy \$2 (outside U.S. \$20 and \$3).

Send address changes to: The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second Class Postage paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by

The Lawhead Press, Inc., Athens, Ohio

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SECOND OPINION

Can Private Practice Survive ... Or Does Anybody Care?

By John H. Boyles, Jr., M.D.

Perhaps I should begin this short article by defining what, in my humble opinion, the private practice of medicine really is. To me, private practice means a contract between the doctor and his patient. This contract involves not only the moral and ethical obligation of the doctor to deliver high quality, efficient medical care, but also includes a financial contract that obligates the patient to pay for such care. This contract focuses the physician completely on his patient. If the patient is paying the bill, then no other party should stand between the physician and his duty to deliver to the patient the best medical care at the most economical price. This contract also guarantees complete privacy of records concerning the patient and his illness. This system, free from governmental controls, has traditionally allowed the patient a free choice of both doctor and hospital. As

long as the consumer (patient) was paying for the services, he was allowed to choose the amount and type of medical care he desired. If he wished a penthouse room on the top floor with private duty nurses, he need only pay for it, and if he wished to maintain his hernia or his tonsils in spite of the inconveniences, he was free to do so. With this type of system as in other true competitive economic systems, health care facilities and manpower truly responded to the marketplace and were not overproduced.

Unfortunately, over the past 25 years the financial obligations of the patient have slowly been removed from the contract of private practice. Since the consumer, therefore, is less and less concerned about the price of the product (health care), cost has invariably risen by ever-increasing amounts.

This escalation of health care costs is particularly evident in our hospitals. Almost all insurance programs are all-inclusive in their coverage of hospital expenses and therefore have completely removed the patient as a method of fiscal control. Hospitals now compete by offering patients and physicians more elaborate equipment and more beautiful surroundings and ancillary services. This type of competition is, of course, cost generating rather than cost saving. In an effort to assure a 95% or better occupancy, the hospitals will go to any end to increase their attending staff and make those attending staffs more dependent upon their particular institution. It is for this reason that hospitals wish to build physicians' offices, will promote closed staffs, will try to make department head choices an administrative duty rather than a staff duty, will establish satellite or

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandrosta-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric, *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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If we, as physicians, do not become more concerned about our profession as a profession, rather than our loyalty to an institution or a specialty, then the private practice of medicine will surely perish.

outpatient clinics using tax-free dollars to compete with private practitioners, and will finally attempt to set up their own closed panel HMOs or preferred practice associations as are developing now in the Denver area.

Hospitals are not alone in their attempt to destroy the doctor-patient relationship and contract that is the basis of the private practice of medicine. The Blue-Shield advance plan promises physicians that their financial world will be improved if they take assignment, and therefore no longer deal financially with their patients. If you stop to analyze this program, it becomes readily apparent that this is yet another blow to the private practice of medicine and will forbid the private practitioner to deal with his patients on an economic basis.

The overexpansion of our hospitals is the final recent development in our medical communities that bodes ill for the future of private practice. The larger the hospitals are, the more ancillary roles they assume in health care delivery. This needless overexpansion will, of course, encourage the hospitals to move into the primary care specialties and will again isolate and restrict the patients' free choice of physician and hospital and the doctors' ability to practice in the most cost efficient manner.

Are these recent developments the beginning of the end for the private practice of medicine? If we as physicians do not become more concerned about our profession as a profession rather than our loyalty to an institution or a specialty, then the private practice of medicine will surely perish. We must continually remind ourselves of what is best for our

community and our patients, in the long run, and not what is best for our hospitals and doctors. We must remember certain principles and fight to maintain them if we are to prevent overregulation of the health care industry and ultimate lack of quality.

What should these guidelines be to preserve the private practice of medicine? I think that there are a few basic concepts that we should keep in mind in our deliberations of any policy changes, hospital bylaw changes, or new organizational changes in insurance or health care delivery.

1. Any system that takes away from the patient his right to freely choose his physician and hospital should be vigorously opposed.

2. Any system which locks in a group of patients to a hospital or list of doctors also should be opposed. This type of system completely destroys true economic competition. In true economic competition, any legitimate licensed physician or hospital should be able to compete for that patient's health care dollar.

3. We should encourage our government to end subsidies for hospitals' HMOs, medical students, etc., that contribute to the overproduction of both facilities and manpower.

4. We must encourage insurance systems that will return to the true insurance principle. Various systems of co-pays, deductibles or prepaid plans should be offered to the consumer so that he may choose the type of health care he desires and full dollar coverage will then be totally eliminated.

5. We must strive to return the hospital to its basic role of caring for the acutely ill. There is no reason for hospitals to be in drug dependency

programs, ambulatory care centers, alcohol rehabilitation programs, real estate (physicians' offices), or other activities unrelated to the care of the acutely ill.

6. We must encourage our government to stay out of the medical care system of our country. We should urge them to repeal the PSRO and health planning laws which have failed so miserably.

7. We should reassert ourselves in our hospitals and seek to work in harmony with hospital-based physicians. As medical staff members we should have the responsibility of choosing heads of departments within the hospitals and should have a voice in future hospital planning. We must remind our chiefs-of-staff that they are representing the practicing physician in the private practice of medicine and not the hospital.

8. We must renew our devotion to the cause of unity to save individual liberty and responsibility.

I hope with all sincerity that the private practice of medicine can survive. If we can return the patient to a status where he has again fiscal responsibility, I think that true competition can prevail. The patient is the only fair and equitable control of the price of medical care. A true competitive marketplace always produces the best product at the least cost.

John H. Boyles, Jr., M.D., is a member of the OSMA and practices in Dayton, Ohio. Dr. Boyles is also President of the Montgomery County Medical Society.



HOMER A. ANDERSON, M.D., Columbus, was reelected president of the board of trustees of the Medical Bureau. **JAMES E. MATSON, M.D.**, Worthington, was elected secretary-treasurer.

DONAVIN A. BAUMGARTNER, M.D., Moreland Hills, was named director of emergency services at St. Luke's satellite emergency/ambulatory center. Dr. Baumgartner also will head the new Chagrin Valley Medical Center (formerly Curtiss Clinic) emergency facilities in South Russell. Dr. Baumgartner has been practicing surgery at the Curtiss Clinic since 1967.

JOHN I. BISKIND, M.D., Cleveland, was appointed director of the division of obstetrics and gynecology at Hillcrest Hospital. Dr. Biskind is a clinical instructor for the department of obstetrics and gynecology at Case Western Reserve University School of Medicine.

PAUL COOLEY, M.D., Swanton physician, was honored for his 26 years of service in the community. Dr. Cooley left his Swanton practice June 29 to begin employment in industrial research in Texas.

JOSEF E. FISCHER, M.D., Cincinnati, was named chairman of the board of the Cincinnati Chamber Orchestra. Dr. Fischer is chairman of the department of surgery at the University of Cincinnati Medical Center.

DAVID GILLESPIE, M.D., Broadview Heights, was honored for taking the lead in developing associate degree and certificate programs in respiratory therapy at Cuyahoga Community College. Dr. Gillespie served as medical director of therapy programs from 1969-1981 and helped implement training of students in area hospitals.

The Ohio Psychiatric Association and the Ohio Medical Association have commended **MAX D. GRAVES, M.D.**, Springfield, for his outstanding leadership and professional contributions. Dr. Graves is acting clinical director for Mental Health Services for Clark County, Inc. and has been a local practicing psychiatrist for 33 years.

MARVIN G. GREEN, M.D., Columbus, was appointed by Mayor Tom Moody to the Columbus Board of Health. Dr. Green is chief of the department of internal medicine at St. Anthony Hospital; a member of the board of trustees to the Peer Review Systems, Inc.; and a medical representative to the Central Ohio Chapter of the Arthritis Foundation.

The St. Anthony Hospital medical library was recently dedicated to **PHILIP B. HARDYMON, M.D.**, Columbus. Dr. Hardymon is director of continuing medical education and has served as chief of staff as well as chief of the department of surgery and chairman of the section of general surgery at St. Anthony. Dr. Hardymon also is clinical professor of surgery at Ohio State University.

S. AMJAD HUSSAIN, M.D., Toledo, was elected president of the Association of Pakistani Physicians of North America. Dr. Hussain is clinical assistant professor of surgery, Medical College of Ohio at Toledo and chairman of the department of surgery, St. Charles Hospital.

JACK R. KIRSCHNER, M.D., Cincinnati, was elected secretary of the Southwestern Ohio Chapter of the American Heart Association. Dr. Kirschner is associate clinical professor of medicine at the University of Cincinnati.

New trustees on the board of the Greater Cleveland Hospital Association include: **JAMES S. KRIEGER, M.D.**, executive assistant to the chairman of the Cleveland Clinic Foundation, and **THEODORE J. CASTELE, M.D.**, radiology director of Lutheran Medical Center.

LOUIS H. LEVINE, M.D., Chagrin Falls, was appointed director of the pathology division at Hillcrest Hospital. Dr. Levine is president of Pathology Laboratory Consultants, Inc.

JOSEPH E. LEVINSON, M.D., Cincinnati, was named Greater Cincinnati's Medical Researcher of the Year by the Cincinnati Coalition of Persons With Disabilities and Blue Cross and Blue Shield of Southwest Ohio. Dr. Levinson is professor of medicine and pediatrics at the University of Cincinnati Medical School and director of the special treatment center for juvenile arthritis.

The Mahoning County Medical Society honored **ROBERT A. LIEBELT, M.D.**, Youngstown, with a plaque for his years of dedication to medicine and medical education. Dr. Liebelt is retiring as provost and dean of the Northeastern Ohio Universities College of Medicine.

E. GORDON MARGOLIN, M.D., Cincinnati, was elected to a three-year term on the board of the Alexander Graham Bell Association for the Deaf. He has been appointed to serve on the board's executive committee and the long-range planning committee. Dr. Margolin is director of internal medicine at Jewish Hospital.

Ballenger, Sabga Win Honors in '82 Golf Tournament

JORGE MEDINA, M.D., Willoughby, is the recipient of the Lake County Bar Association's Liberty Bell award. Dr. Medina, a surgeon, was honored for his work as president of Lake County Blue Coats, an organization that gives financial support to families of police and firemen killed in the line of duty.

Ohio State University College of Medicine, class of 1982 named **JOHN MINTON, M.D.,** Upper Arlington, Professor of the Year. Dr. Minton has received numerous awards including the Mead Johnson Award for graduate training in surgery; the Doctor of Philosophy degree in microbiology, 1969; the James IV Association of Surgeons - 40th Traveling Fellow to the British Isles, 1975; and the Ohio State Medical Association Gold Teaching Award, 1977. He is the American Cancer Society Professor of Clinical Oncology; the Ohio Chairman for the Field Liaison Fellows of the American College of Surgeons Commission on Cancer; and has published more than 140 articles.

HENRY MOBLEY, M.D., Dayton, surgeon, is the new chief of staff and **S. HENRY DIMLICH, M.D.,** Dayton, urologist, is chief of staff-elect of Miami Valley Hospital.

E. GATES MORGAN, M.D., Akron, was named medical director at the Firestone Tire and Rubber Company. Prior to joining Firestone in 1978, Dr. Morgan was in private practice for 23 years as a general surgeon in Akron.

LESTER PERSKY, M.D., Cleveland, received the William P. Burpeau Award for his outstanding work in the field of urology. The award was presented by the New Jersey Academy of Medicine which is affiliated with the American Urological Association of which Dr. Persky is a past president.

For the second consecutive year, Ralph R. Ballenger, M.D., of Columbus, won low gross honors in the Ohio State Medical Golfers Tournament.

Dr. Ballenger recorded a one-over-par 71 on the Marion Country Club course to earn an inscription on the Richard P. Bell, M.D. Trophy. His score was two strokes under the 73 he shot to win the 1981 OSMGA low gross championship at Ashland Country Club.

Capturing low net honors was Gabriel A. Sabga, M.D., of Lorain. Dr. Sabga carded a score of 80 minus a 17 stroke handicap for a net score of 63. His name will be inscribed on the Dr. Ray Stephens Memorial Trophy.

Winners in age flights among the 115-member field were as follows:

Low gross, age 39 and under — Charles D. Parsons, M.D., Springfield (75)

Low net, age 39 and under — H.

Stephen King, M.D., Columbus (65)

Low gross, age 49 and under — Robert E. Barkett, M.D., Mansfield (78)

Low net, age 49 and under — Kyung H. Kim, M.D., Sandusky (66)

Low gross, age 59 and under — William M. Emery, M.D., Ashland (76)

Low net, age 59 and under — James L. Secrest, M.D., Mansfield (64)

Low gross, age 69 and under — C.T. Kasmersky, M.D., Columbus (78)

Low net, age 69 and under — P.S. Test, M.D., Mansfield (65)

Low gross, age 70 and over — Edward B. Young, M.D., Lima (90)

Low net, age 70 and over — Robert C. Kirk, M.D., Columbus (70)

Age flight winners repeating from 1981 included Drs. Emery, Secrest, and Kasmersky.

Dr. Young, low gross winner in the age 70 and over flight, has missed only one OSMGA tournament since 1950.

Looking ahead to a good day on the course are (l. to r.): Chester C. Winter, M.D., Columbus; Edward B. Young, M.D., Lima; William O. Light, M.D., Lima; and William M. Wells, M.D., Newark.



continued on page 595

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Medical Practice Management Desk Book. Charles H. Walsh and Morton Walker; Prentice-Hall, Inc.; \$39.50.

This desk book supplies original and innovative information that can boost income without sacrificing professional standards of excellence. Written in nontechnical language, the topics covered include. . .how to determine if a community will support a profitable practice; the 12 strategic management approaches to developing a practice; the 10 commandments of human relations; a 10-point checklist to prevent malpractice claims; the secrets of successful partnerships; the 10 advantages of group practice and the 10 disadvantages; the 7 most common questions asked about medical incorporation; 7 hints for utilizing the office staff's time when you are away; and the 5-month follow-up billing procedure.

In addition, the book is filled with cautions, pitfalls to avoid, checklists and model letters, gathered from the author's research of more than 1,000 of their clients.

To order a copy, write the publisher, Prentice-Hall, Inc., at Englewood Cliffs, New Jersey 07632.

Vitamin C in Health and Disease.

By Tapan K. Basu, Ph.D., and C. J. Schorah, Ph.D.; AVI Publishing Co., Inc.; \$19.95.

The authors make assessments of an appropriate level of Vitamin C in humans, and explore the vitamin's controversial role in human nutrition, as a cofactor in hydroxylation reaction and its possible function in the treatment of a number of diseases such as immune-deficiency conditions, behavioral changes and arterial degeneration. To order, contact the publisher at 250 Post Road East, P.O. Box 831, Westport, Connecticut 06881.

Diseases Transmitted by Rats and Mice. By Walter J. Weber; Thomson Publications, \$13.00.

Rats and mice often are considered man's worst enemy. That image is reinforced by a review of medical literature — both veterinary and human. The potential for transmission of disease organisms to humans and domesticated animals is demonstrated by numerous laboratory tests and documented situations which have shown the capability of rats and mice to transmit many microbial and parasitic agents.

The book reviews more than 200 pathogenic microorganisms, helminths and arthropods associated with rodents.

The most tragic effects, the author points out, are the possible unrecognized adverse effects in children — including birth defects in the unborn child. Disease organisms from rats and mice may be spread by bites, ectoparasites, urine, feces, hairs, feet, oral, ocular or nasal secretions, so they can harm people without their ever seeing or suspecting their presence.

Copies of the book may be ordered from the publisher, P.O. Box 9335, Fresno, California 93791.

Incorporating the Professional

Practice. By George E. Ray; Prentice-Hall, Inc.; \$39.35

The Third Edition of this now classic work is even more informative than its predecessors in helping professionals decide whether to incorporate, and how to operate the professional corporation for maximum benefit once it has been established.

The revised edition reflects all the changes brought about by the 1981 Tax Act with respect to professional corporations. Topics covered

include. . .why incorporate?. . .how to organize and operate the corporation. . .retirement plans. . .planning the estate of the professional. . .and how to sell or terminate the corporation.

For further information, or to order a copy, contact the publisher, Prentice-Hall, Inc., Business and Professional Books Division, Englewood Cliffs, N.J. 07632.

Estimating Fetal Age with Ultrasound.

General Electric Company. A pocket reference guide for obstetricians to facilitate the calculation of fetal age from ultrasound measurements now is available from General Electric's Medical Systems Operation.

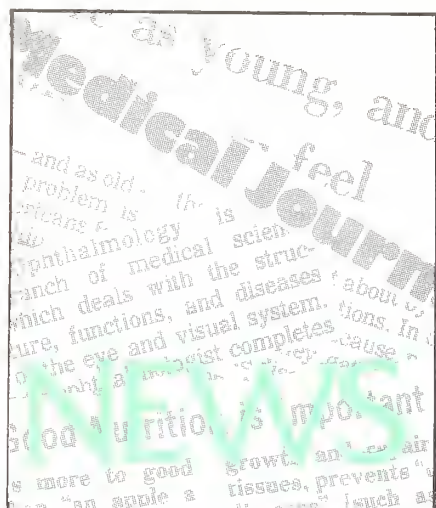
The guide provides tables to calculate gestational age by Biparietal Diameter (BPD), femur length (FL), fetal abdominal circumference (AC) and crown-rump measurements (CRL). Another table lists BPD, AC and head circumference as functions of gestational age.

Write for Publication 5374 to General Electric Company, Medical Systems Operations, P.O. Box 11944, Milwaukee, Wi. 53201-0944.

On Monsters and Marvels. By Ambroise Pare. Translated, with notes, by Janis L. Pollister. University of Chicago Press; \$20.00.

Fact and fiction, empirical evidence and imaginative invention are side-by-side in this eclectic catalogue. All are overlaid by Pare's concern for objective inquiry.

Copies of the book may be ordered from the publisher, 5801 South Ellis Avenue, Chicago, Illinois 60637.



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OSU kicks off new "football Saturday" seminars



The Ohio State University's Department of Surgery is going to give you a valid reason (as if anyone has ever needed a valid reason) to come to OSU football games this fall.

For the first time, a series of Saturday morning seminars, designed for family physicians, primary care physicians and surgeons is being offered this fall, prior to each home game. Topics to be covered include: Vascular Disease, Trauma, Sports Injuries, Cancer Update, Urinary Disease and Abdominal Tumors of Infancy and Childhood. Each seminar has been approved for 2 credit hours,

Category I.

And just so your spouse and guests can occupy *their* time before the "Big Game," a series of programs of general interest has been developed, including: Take Charge of Your Life; Managing Stress; Shutterstuff; Fitness; and Financial Planning.

Monica V. Brown, Program Coordinator in the Department's Office of Continuing Medical Education is the person to contact for more information. You can reach her by writing: N750 University Hospital, 410 West Tenth Avenue, Columbus, Ohio 43210, or call 614-421-8551.

Low risk mastectomy patients now have new option

It is now feasible for some women facing a mastectomy operation to have the option of immediate breast reconstruction, provided this is the joint recommendation of their cancer and plastic and reconstructive surgeons.

Recent improvements in medical technology have made this choice possible for selected low risk mastectomy patients. A well-documented three-year study shows favorable patient reaction to initiation of breast reconstruction following a cancer operation during the same hospital visit, according to a recent article in *Plastic and Reconstructive Surgery*, the official journal of the American Society of Plastic and Reconstructive Surgeons.

The study covers 30 mastectomy patients at Bryn Mawr Hospital, Bryn Mawr, Pa., from 1978-1981. It indicates medical success in providing breast

restoration to qualified cancer patients right after mastectomy, and endorsement of the procedure by the patients themselves, based on in-depth interviews.

The team that performed the 30 consecutive operations and spearheaded the study included Dr. Thomas G. Frazier, cancer surgeon, and Dr. R. Barrett Noone, chief of plastic surgery at Bryn Mawr Hospital.

"We realize that the question of reconstruction and its timing must be made on an individual basis in joint consultation among the patient, general surgeon and plastic surgeon," Dr. Frazier said. "Many patients who undergo mastectomy never have reconstruction. Others benefit from reconstructive operations performed a few months later, while some carefully chosen patients may benefit from immediate reconstruction."



Immediately after the operation, the completed breast mound is closed with stitches that are later removed.

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New from Public Affairs. . . two pamphlets, designed to help your patients sort fact from fiction on two popular topics — exercise and low back pain. *Listen to your body: exercise and physical fitness* details how to design an exercise program, including precautions that should be taken; and *Low back pain — what it is, what can be done*, provides the patient with some sensible, sound advice on the problem. To order copies of either or both, write: Public Affairs Pamphlets, 381 Park Ave., S., New York, N.Y. 10016.

Previously available to internists only. . . the American Society of Internal Medicine (ASIM) has decided, in light of today's worsening economic climate, that all physicians could find use for their handy brochure on "Medicare: What it will and will not pay for." The brochure explains who is eligible, how to claim benefits, and what a "reasonable charge" is — all in an easy-to-read style, designed especially for elderly patients. For more information, write ASIM, N.W., Suite 500, Washington, D.C. 20005.

Pharmacotherapy is a new bimonthly journal which explores rational therapeutics and clinical drug research. Subtitled *The Journal of Human Pharmacology and Drug Therapy*, the publication publishes four categories of review articles in addition to original research articles. In addition, critical reviews of drugs that have been recently marketed in the United States are included, as well as state-of-the-art reviews on drug treatments, and reassessments of older drugs. The annual subscription rate is \$55.00. For sample copies or further information, write: *Pharmacotherapy* Publications, Inc., 112 School St., Carlisle, Ma. 01741.

Enzyme immunoassay (EIA) tests are revolutionizing the field of rubella testing by providing highly accurate information to the physician within 24 hours.

EIA tests that are specific for rubella IgG or rubella IgM antibodies provide the physician with information to

determine immune status, confirm primary infection and screen for congenital rubella syndrome.

Since the test is not affected by rheumatoid factors, the presence of IgG antibody, or viral infections other than rubella, virtually all false positive results are eliminated.

The test, Rubazyme-M, is being marketed by Abbott Laboratories.

By midnight, December 31, 1982, you should have sent to the Treasurer, State of Ohio, the renewal application for your medical license with a check for \$100. The renewal application card will contain a statement that you will certify by signature that you have met the requisite number of CME hours for license renewal. The renewal card will be mailed to you on or before October 1, 1982.

Important! If you have moved since your last license renewal, don't forget to contact the Records Department of the State Medical Board in writing. The address is 65 South Front Street, Suite 5101, Columbus, Ohio 43215.

More study needed on sound ballistics

Gunshot wounds often keep emergency rooms busy on Saturday nights, so knowledge of the pathology wrought by weapons often can be helpful to even civilian surgeons, claims Norman Rich, M.D., professor of surgery and chairman of the department at the Uniformed Services University of the Health Sciences, in a recent issue of *U.S. Medicine*.

"There are few doctors who have studied anything about wound ballistics. What is it? It's an interest in the wounding power of missiles."

According to data from the Bureau of Vital Statistics, there have been 30,000 deaths a year from gunshot wounds (mostly from handguns) in the U.S. in the past 10 years. As Dr.

Rich points out, "The sophisticated weaponry that has crept into civilian life makes a knowledge of wound ballistics important for surgeons in all walks of life."

For example, last year when President Reagan was shot with a devastator round, phone lines were buzzing as attempts were made to find out what a devastator round was.

"They were being manufactured in Atlanta, yet it was amazing how few people had any understanding at all as to what was the danger if that missile was left in the thoracic cavity of the President, what was the danger to the surgeon in trying to remove that missile."

OSMA sets dates for Leadership Conference

Crisis Communications, The Future of Government-funded Health Care Programs, Marketing and Competition in Health Care, Developing Political Savvy, Forming Medical/Business Coalitions and Investing in the '80s are just some of the topics that will be covered when the OSMA conducts its first Leadership Conference November 11-13.

The conference will begin Thursday afternoon with three preconference seminars, and will continue all day Friday and until noon on Saturday. Don't miss this important seminar. Registration will be limited to 200. Complete details will appear in the September OSMAgram.



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Colleagues (continued)

GEORGE W. PAULSON, M.D., Columbus, was named director of the division of Neurology at Ohio State University Hospitals. Dr. Paulson is a professor at Ohio State's College of Medicine and is program director of neurology for Riverside Methodist Hospital.

DENIS RADEFELD, M.D., Lorain, was appointed medical director of Lorain Community Hospital.

BEN H. REED, JR., Delta, was named a representative delegate to the Ohio Heart Association. Dr. Reed is the retiring president of the Northwestern Ohio Chapter.

DONALD SCHERMER, M.D., Pepper Pike, was appointed chief of the division of dermatology at Mount Sinai Medical Center. Dr. Schermer is an assistant clinical professor of dermatology at Case Western Reserve University School of Medicine.



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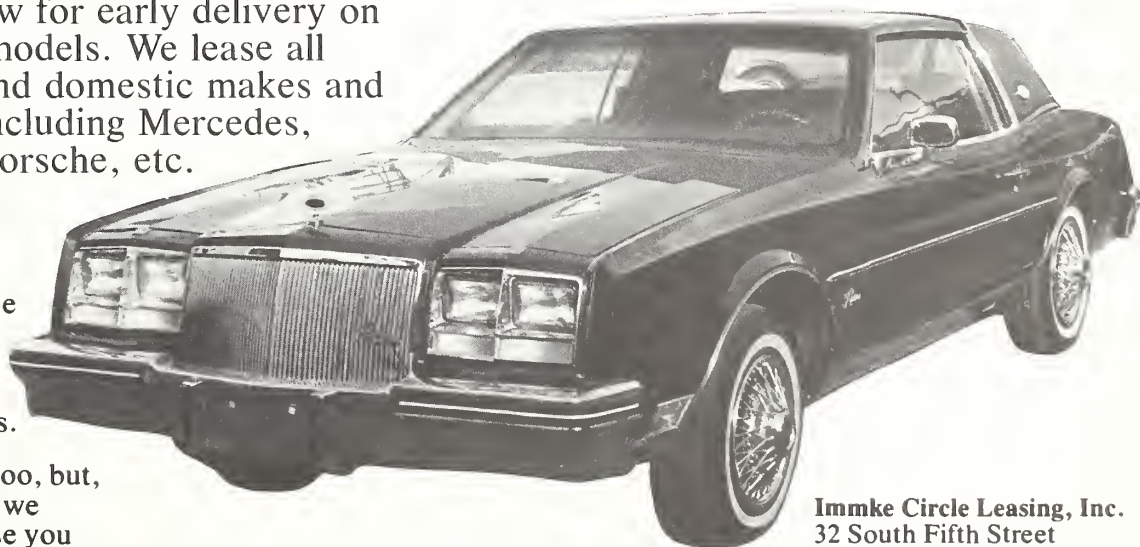
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Breaking New Ground

Questions and answers about OSMA's new Group Professional Liability Plan

By Carol Wright Mullinax

Much has been written in the past few months about the new Group Professional Liability Insurance being offered by the Ohio State Medical Association (OSMA) and underwritten

by the Physicians Insurance Company of Ohio (PICO). In this column, C. Douglass Ford, M.D., President of the OSMA, answers some commonly asked questions about the new plan.

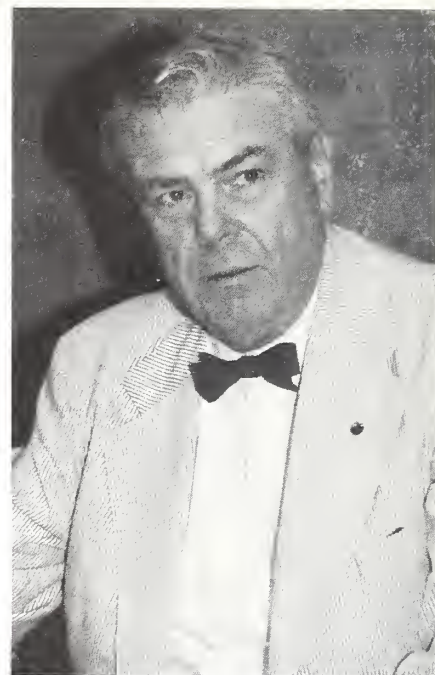
JOURNAL: Since the OSMA has broken new ground by offering group professional liability insurance, would you explain how the idea for group professional liability insurance evolved?

DR. FORD: The OSMA has always wanted to make certain that its members have access to the best professional liability insurance available — at low cost. In 1976, that meant forming its own insurance

company — PICO — to assure the members that the liability insurance they needed would be available. In 1982, it means we offer group professional liability insurance. PICO, at the request of the OSMA Council, began searching for alternatives to traditional professional liability insurance a few years ago. With experts predicting yet another "malpractice" crisis, we knew it was vital to take steps now to make certain

our members have low-cost insurance available without sacrificing reliability. We felt group insurance, carried by the OSMA and underwritten by PICO, offered the best of both worlds. Group insurance is less expensive to administer, thereby permitting the reduction of premiums. And, since the plan is underwritten by PICO, our members continue to benefit from PICO's physician-oriented philosophy of operation.

“Because of administrative savings, group insurance is less expensive than individual insurance. We are able to pass those savings along to our members as a 20 percent reduction from the previous rates . . .”



C. Douglass Ford, M.D., President of the Ohio State Medical Association.

JOURNAL: How is the Plan actually set up?

DR. FORD: The Group Policy is issued by PICO to the OSMA. We, in turn, issue individual certificates of coverage to our members who take part in this plan. The available limits for occurrence primary medical professional liability insurance are \$100,000/\$300,000 and \$200,000/\$600,000. Excess coverage will continue to be written by PICO and will be offered through its network of independent agencies. PICO's risk classifications will remain unchanged.

JOURNAL: You mentioned a cost savings. Could you please explain that?

DR. FORD: Because of administrative savings, group insurance is less expensive than individual insurance. We are able to pass those savings along to our members as a 20 percent reduction from the previous rates. Another advantage of a group policy is that it allows us to include a profit sharing agreement. This means our members will participate in any future profits from the total business volume of the plan, including the income from the investment of premium dollars.

JOURNAL: How will the new

Group Plan be implemented?

DR. FORD: It is already in effect. Starting July 1st physicians who held PICO Professional Liability Policies were automatically enrolled in the Plan, with all of the benefits — including the lower premiums — on the renewal dates of their policy. Excess coverage will continue as before and will be renewed on the renewal date of the current policy.

JOURNAL: What about physicians who are not PICO policyholders?

DR. FORD: We hope our members who are not presently PICO policyholders will take a look at the new Group Plan. If they decide to change carriers, they can do this by contacting the OSMA prior to the expiration date of their present policy.

JOURNAL: Will a physician be losing anything by switching from an individual liability policy to a group policy?

DR. FORD: On the contrary, our members will be gaining a great deal by signing up for the new Group Plan. Besides the benefits I've already mentioned — the 20 percent rate reduction and the profit sharing agreement — there are other, long-term benefits that I feel make this Plan especially appealing. The most important of these is the continued

association with PICO. As a physician-conceived and oriented company, PICO has always offered services that I feel are vital to a physician. These benefits are included in the new plan. For example, primary partnership and corporation coverage is provided at no charge if all members of the partnership or corporation are participants in the Plan. In addition, physician consent is required for settlement, before judgment, of any claims covered. Another benefit is a six months premium billing. And PICO and the OSMA haven't forgotten about new member practitioners. Their discount remains in effect, plus the 20 percent rate reduction.

JOURNAL: If a physician has a claim or suit, how will it be handled? Will group coverage make any difference in the handling of the claim?

DR. FORD: The fact that the new policy is a Group Plan makes no difference whatsoever in the handling of a claim. All claims are handled individually, the same as they were before the initiation of the new Group Plan.

JOURNAL: Could you please tell our members a little about the suit pending over this new type of professional liability insurance?

"I want to personally assure anyone who presently holds our group professional liability policy . . . that their coverage contract will remain in effect. They have nothing to worry about . . ."

DR. FORD: Yes. First a little background. As I mentioned earlier, this is a new concept in professional liability insurance. It was believed previously that professional liability insurance could not be offered as a group policy. However, at the request of OSMA Council, PICO reviewed the laws and regulations concerning insurance and determined that, while it had never been done before, there were no legal prohibitions against this type of insurance. I might add that group professional liability is offered in several other states. However, the Ohio Department of Insurance issued an order against implementing the

Plan. The OSMA and PICO brought suit in the Court of Common Pleas to appeal that order. I think it is important for our members to know that we feel we are right in this issue and are confident that we will prevail. But I also want to personally assure anyone who presently holds our group professional liability policy or anyone who is considering purchasing it, that, win or lose, their coverage contract will remain in effect. They have nothing to worry about.

JOURNAL: What prompted the OSMA to initiate this new type of Group Professional Liability Insurance?

DR. FORD: As I said before, the prediction of a "malpractice" crisis provided the impetus for us to start looking into ways to reduce the cost of professional liability insurance premiums. But the real reason goes deeper than that. The OSMA is a service organization. One of the ways we measure our success is in anticipating and responding to the needs of our members. We feel this new insurance plan is one of the more important member services we have offered and I hope our members will take advantage of it.

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1. Promoting Health/Preventing Disease: Objectives for the Nation. U.S. Department of Health and Human Services, November 1980.

*An in vitro simulation of gastric ulcer acid level conditions based on standard laboratory methodology. Data on file. Ayerst Laboratories. Acid neutralizing capacity of RIOPAN and RIOPAN PLUS = 13.5 mEq/5 ml or tablet.

Football's "Twelfth" Man

The 1982 Outstanding Team Physicians

By Robert D. Clinger

Ohio has many outstanding team physicians who administer to the needs of high school athletic teams throughout their communities. But it is those "special" team physicians — those who have provided 20 years of service, and been endorsed by professional and school officials — who are recognized each year by the Joint Advisory Committee on Sports Medicine of the Ohio State Medical Association, and Ohio High School Athletic Association, in cooperation with the Ohio High School Football Coaches Association.

The Ohio Outstanding Team Physician Awards is a program that

began in 1975 and has totaled 64 recipients to date — including six physicians who received awards in ceremonies this past July in Canfield, Ohio.

In addition, five physicians have received Special Awards for Outstanding Service to Sports Medicine in Ohio. Criteria for this honor include extended leadership and achievement in major sports medicine projects at the local, state and national levels.

The Ohio State Medical Association wishes to congratulate this year's award winners:

Charles M. Comella, M.D.

New Philadelphia, Ohio

"I feel very confident on the sideline coaching a game with the knowledge that Dr. Comella is at my side to handle any situation that might arise. I refer to him as our twelfth man on the field."

—Lawrence "Art" Teynor
Athletic Director, Head Football
Coach
Tuscarawas Central Catholic High
School
New Philadelphia, Ohio

Dr. Comella looks back on his 20 years of experience as team physician for Tuscarawas Central Catholic High School and reflects that the years have "brought me into close contact with hundreds of student athletes who participated in sports not for material rewards, but for personal satisfaction of contributing to the team effort."

The chief of surgery at Union Hospital in Dover, Ohio, Dr. Comella is past president of Tuscarawas County Medical Society and the Union Hospital Medical Staff. He is a



Charles M. Comella, M.D.

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Diplomate of the American Board of Surgery and a Fellow of the American College of Surgeons.

Gerald F. Finn, principal of Central Catholic said, "We . . . consider him an integral part of our football staff. His

quiet, self-effacing manner has been a model for our youth, several of whom have gone on to medical studies."

Dr. Comella and his wife, Janet, have four daughters and one son.

James B. Daley, M.D.

Fairview Park, Ohio

"Dr. Daley has earned an enviable reputation through his volunteer services, not only to the people of his own community. . . but to the residents of the entire state as well."

Dr. Daley's service, not only to Fairview High School where he has served 28 years as team physician, but to his community and profession as well, have earned him the respect of colleagues and nonprofessionals alike.

He is a recipient of Fairview Park's "Citizen of the Year" award, and the Cleveland Academy's "Distinguished Service Award" which honored his leadership in organizing and coordinating a countywide as well as statewide disaster network. He has also been honored for 13 years as a member of Fairview Park's Board of Education, eight of which were spent as vice-president.

Nor has his service as team

—**Robert M. Zollinger, Jr., M.D.**
Immediate Past President
Cleveland Academy of Medicine
Cleveland, Ohio

physician been overlooked by those at Fairview High.

"Dr. Daley's record is one of longevity, dedication and service unparalleled in Fairview history," says Fairview High School Principal Walter R. Sheffield. "He has become a friend of parents and students alike. He has given the highest quality of service to our young people."

Dr. Daley and his wife, Mary Elizabeth, have three sons, three daughters and ten grandchildren.



Dr. and Mrs. James B. Daley

Robert B. Elliott, M.D.

Ada, Ohio

"I have been in this community for nine years. During those nine years, Dr. Elliott has been present on the sidelines at every football game for both schools. His support of these teams has earned for him the highest respect of the citizens of this area."

—**Richard E. Chambers,**
Publisher, **Ada Herald**
Ada, Ohio

After 27 years as team physician for Ada High School, and 20 years as team physician for Ohio Northern University, Dr. Elliott remarks, "The experience of being a team physician has been rewarding, challenging and educational. The memories are treasured, and the anticipation of future years is eagerly awaited."

A family practitioner, Dr. Elliott has done more than providing gratis athletic physical examinations to team

members. He has donated athletic equipment (including weight scales and sling psychrometers), books, magazines and anatomical models to Ada's elementary and high school.

Ohio Northern's recently retired athletic director adds that Dr. Elliott always makes himself available to our athletes, and is truly a physician's doctor.

Dr. Elliott, and his wife, Margaret, have five sons and one daughter.



Dr. and Mrs. Robert B. Elliott

Harold D. Erlenbach, M.D.

New London, Ohio

"Dr. Erlenbach is a man with very high principles, both personally and professionally. He keeps abreast of the latest and best in medical practices. His care has been extended to participants from other schools on the field, on the court, even post-game."

One example of the extension of Dr. Erlenbach's care as a team physician came during a game in 1974. He is credited with saving the life of a football official, suddenly stricken by a heart attack. But such conscientiousness is not limited to the field. Another example surfaced early during his "career" when he told school officials he could no longer in good conscience continue mass physical examinations. Instead, he suggested each athlete set up an appointment for a complete examination — at no charge to the participant. It's a practice he continues today, for approximately 250 students a year.

Combining that with his responsibilities as chief of medicine

—F. Paul Nestor
Assistant Principal
New London, Ohio

and director of Respiratory Therapy at Fisher-Titus Hospital in Norwalk, Dr. Erlenbach keeps busy professionally. In addition, he and his wife, Margaret, are active in AFS, and Rotary programs which involve them as hosts for visiting foreign exchange students.

The students at New London High School are enthusiastic supporters of Dr. Erlenbach, and recently tapped him as the initial honoree to the NLHS "Athletic and Academic Hall of Fame." It's an honor well earned.

The Erlenbachs have two sons and one daughter.



Dr. and Mrs. Harold Erlenbach

Eugene R. Turner, M.D.

Middletown, Ohio

"He has always maintained the welfare of the student-athlete first, the participation factor second."

Dr. Turner was, himself, a Middletown High School athlete before returning to the field as team physician 22 years ago. His service in that capacity includes assistance in establishing a local Saturday clinic to treat area athletes; helping to conduct preparticipation physicals free of charge; serving as site physician for the Ohio High School Athletic Association football playoffs; and providing emergency help for injured athletes whenever that help is needed.

—Jack Gordon
Head Football Coach
Middletown High School
Middletown, Ohio

Charter member, and president of Associated Anesthesiologists, Inc., Dr. Turner is involved at the local, state and national level of several different medical organizations, and serves as a church elder.

He and his wife, Jane, have four sons, all of whom participated in athletics at Middletown High School.



Eugene R. Turner, M.D. (left) and David M. Bell, M.D., Cleveland, Chairman of the Sports Medicine Committee

Tennyson Williams, M.D.

Columbus, Ohio

"His interest in youth was reflected in his concerns about their safety, and in his development of techniques and equipment that would reduce or eliminate injuries."

—Gerald Cornell
Former Football Coach
Delaware Hayes High School
Delaware, Ohio

Although Dr. Williams left his position as team physician for Delaware Hayes High School in 1976, to assume his current position as Chairman, Department of Family Medicine, the Ohio State University College of Medicine, he still is remembered by coach, school officials, and students as "something special."

He is credited by Delaware Hayes' former football coach, Gerald Cornell, with generating, through personal contacts, substantial interest on the part of other physicians to support and improve scholastic athletic programs throughout Delaware County.

"His service was exemplary in every way," says Richard K. Snouffer, Delaware Hayes' principal.

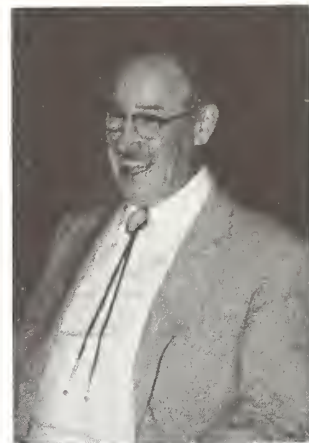
Former president of the Delaware County Medical Society, and current

president of the Ohio Academy of Family Physicians, Dr. Williams conducts considerable research into projecting future needs for family physicians in Ohio.

But it is not so much his service to the medical community, but to the school community upon which Dr. Williams reflects:

"I had the opportunity to return to the community many special things it afforded me; the opportunity to have a unique view of youngsters growing into adults, and the opportunity to relieve high school coaches of certain decisions in order to devote their full attention to doing what they do best — guiding young people toward fruitful adult lives."

Dr. Williams and his wife, Marianne, are the parents of three daughters and one son.



Tennyson Williams, M.D.

Special award for Outstanding Service to Sports Medicine in Ohio

Brady F. Randolph, M.D.

Hamilton, Ohio

Dr. Randolph has been involved in sports medicine since 1960 when he became chairman of the Butler County Medical Society Sports Medicine Committee. Since then, he has participated on the Joint Advisory Committee on Sports Medicine of the Ohio State Medical Association and Ohio High School Athletic Association, serving as Chairman from 1980-1982.

During his term as chairman, Dr. Randolph spearheaded two major innovations in Ohio scholastic sports medicine. First was the development of guidelines for in-service education in health and safety of athletes for scholastic coaches. Second was an active campaign, including testimony before the Ohio General Assembly which paved the way for adoption of state legislation relieving volunteer physicians of liability during performance of their duties with scholastic athletic teams.

Recently, Dr. Randolph was

appointed medical representative to the Football Rules Advisory Committee of the OHSA, replacing the late Sol Maggied, M.D.

In addition to his interest in sports medicine and his practice in orthopedic surgery, Dr. Randolph is active in numerous community as well as professional activities. He has served as President of the Hamilton Rotary, the Butler County TB and Respiratory Disease Association and the Hamilton Safety Council. He is also the recipient of the "Distinguished West Virginian Award," an honor inspired by his annual trips to West Virginia University, where he twirls the baton as drum major for WVU's alumni band.

Dr. Randolph and his wife, Evelyn, reside near Darrrtown. He has two sons and two adopted daughters from a previous marriage. Mrs. Randolph has one son from a previous marriage.



Brady Randolph, M.D. (left) receives his special citation from H. Judson Reamy, M.D., Dover, Seventh District Councilor to the OSMA.

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Corporate Health Care

When hospitals mean business

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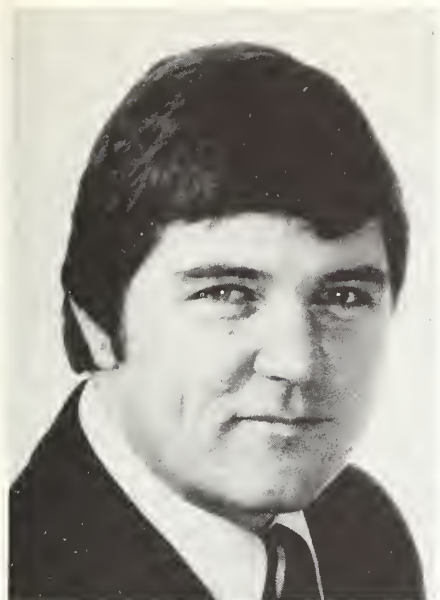
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Ronald B. Berggren, M.D.

Foreword

By Ronald B. Berggren, M.D.

The significant downturn in our economy, the growing financial instability of hospitals and the continued increase in hospital costs have created a great amount of concern among the nation's hospitals.

In response to these trends, administrators and boards of hospitals are applying business practices to their institutions, allowing them to maximize the use of capital. These practices commonly are referred to as the use of management systems. In order to produce the expected cost efficiency, as well as a competitive edge with other hospitals, new entities are being introduced into the "marketplace" which change the appearance and role of familiar institutions in which physicians practice. This response by hospitals to maximize capital is a result of corporate reorganization which has produced national and local multihospital systems.

We hear of the "for-profit" hospital systems, and we criticize them by saying they are out to make money for their stockholders to the disadvantage of the sick. However, the same management systems are being introduced by the not-for-profit institutions to increase the availability of capital and to maximize its use. Both modes of organizations are making every effort to show excess income over expenditure. This excess is channeled differently in each type of organization. Nonetheless, investors in bonds or mortgages expect a return on

their investment as do investors in stock. In each instance, the dedication to the care of the patient at cost or at a loss (low-profit patient) is dependent upon the altruistic concern of the medical staff and the hospital governing body. These patients are eschewed by some institutions in both organizational models.

In general, hospitals which have chosen to reorganize have set up multicorporate structures to separate profit from nonprofit activities under a single holding company. This allows them to increase profitable areas without jeopardizing reimbursement levels. It also allows them to diversify for-profit activities in order to subsidize the nonprofit activities. Most importantly, the restructuring may include the involvement of several institutions. These joint efforts may include acquisition of the hospital, contracts to manage the hospital, joint purchasing and personnel pooling.

We think of the patient as the consumer of health care. However, with the change to the use of business practices, the patient easily can be considered the raw material or **product** in the "health care market" where hospitals compete. If the projections of bed capacity in Ohio are correct, there will be an excess of beds in many areas. The hospitals will have to compete for the **raw material/product**, the patient. There is a myriad of ways that this is being done. In relation to the phenomenon of restructuring hospitals, the development of other

forms of health care is beginning to be seen in existing institutions.

Ambulatory care centers, general or family practice centers, urgent care centers, etc., are being developed by hospitals to increase their access to the patient population. On many occasions these may appear to be in direct competition with physicians or the hospital staff itself.

This issue of the **Journal** is devoted to the various changes that are occurring in the hospital "business." Many of us have begun to see these changes in our communities and in some cases have participated in them. Others are unaware of these changes. All the change is not bad. It is our awareness, our understanding and our response to the change that is important. We must make important decisions regarding our response to these new efforts. Our response starts in our hospitals and in our communities. The hospitals are making these changes out of necessity and the medical staff must participate in the decisions related to the changes. If we don't participate, we will probably find ourselves struggling outside of the new system.

The OSMA Task Force on Competition and Marketing has provided a special program for the OSMA Council on this subject and provides the following articles for your information.

Ronald B. Berggren, M.D., Columbus, is Chairman of the OSMA Task Force on Competition and Marketing.

The New Corporate Hospitals

What are they, and what is their future?

By Montague Brown

Hospital Corporation of America purchases Hospital Affiliates International for nearly 3/4 billion dollars; Humana Inc., a hospital management chain, announces its entry into primary care, predicting 200 centers within next couple of years; Lutheran General Hospital's parent corporation makes deal with emergicenter chain to take referrals and provide back-up care for the clinics.

Movements like these recently have begun to dominate the medical and hospital fields, representing symptoms of fundamental changes. Investors have begun to place large amounts of equity capital into the health-care field, and now are beginning to take a strong role in managing the health affairs which their money buys. While this is most true of hospitals, the physician practice and services are not exempt.

Community hospitals have responded to some of these changes by developing multihospital systems in hope that they might build enough organizational flexibility to compete effectively; stanch reimbursement drains; and build profitable ventures needed for capital formation.

This article will examine some of the major factors fueling this change; some general trends and developments considered most likely to become widespread; and implications for physicians.

Environmental Changes Influencing Trends

Medicare and Medicaid brought many changes, among which was a need for vast amounts of new capital to upgrade and expand hospitals. This change brought a guarantee, or at least a strong expectation, that services used by the elderly and poor could be sold profitably, greatly diminishing the risk of financial failure for hospital operators. Low risk and steady cash flow during recessions proved to be heady attractions for new ventures.

The federal move into financing introduced the need for hospital specialists in reimbursement, planning, capital financing, administrative law and other disciplines not common to community hospitals. Specialists in these areas provide an edge for their provider organizations which can be translated, over time, into market dominance. Such changes on the part of one or more competitors place the more traditional hospital at a competitive disadvantage (just as it probably places the solo or small group practice at a disadvantage when all their large group practice competitors have the expertise).

During the past ten years, the myth that bottomless pits of money would always be available for health care has been dispelled partially, at least. Many

community and public hospitals have suffered severe capital erosion, making it increasingly difficult to replace assets and maintain technological superiority. Better managed, more profitable multihospital systems are increasingly buying, leasing, and contracting to manage such hospitals, thus bringing them into multihospital systems.

The calls for competition and a move away from regulation bring smiles to the entrepreneur who can envision still other opportunities to carve out profitable services and markets from the existing health care system. Thus, we can expect competition themes to be used to pit hospitals against emergicenters, specialty hospitals against general hospitals, primary care centers against traditional practice, and many other imaginable permutations of care systems.

Health care providers must, however, conduct their business under the same competitive rules governing American industry — and in the hospital field this means many new threats for the solo community hospital and many teaching and referral centers. In medicine, it means more competition for traditional forms of practice.

The increased supply of physicians provides innovators with physicians willing to look with favor on new practice forms and arrangements with institutions. At the same time,

hospitals see more physicians able and willing to open freestanding emergenciers, imaging centers, and surgicenters, which compete with them for traditional hospital types of services. If hospital administrators and trustees seem nervous about the potential for physicians who might want to take away some of their types of business, it should be no surprise — nor should it be if hospitals seek to work out arrangements which will help to insure the loyalty of their medical staffs. Traditional alliances should be examined and rethought in light of today's more competitive marketplace.

With all of the changes and challenges just noted, those organizations with the capital (human, technological, organizational and dollar) will be the big winners in the next decade. The multihospital systems and the newly corporately reorganized hospitals are much more apt to have the ideas, resources, and desire to pursue the new opportunities in the marketplace.

Finally, the above noted factors and trends have injected an entirely new element into the American health care scene. Multihospital systems of all descriptions are seeking acquisitions, especially those with profit potential. Since hospitals and community hospitals have been near synonymous terms for years, this development represents something of a revolution in health care, not foreseen ten or so years ago. With the strong push by investor-owned multihospital systems and the Supreme Court's recent clarification on the law of competition, these trends will accelerate.

The New Multihospital Systems

There are basically three different types of multihospital systems. The first and best known is the investor-owned chain. The multiregional or national not-for-profit chain represents another type of system, and the regional system, where patient and physician populations often seem to overlay, make up the third basic type of multihospital system.

The investor-owned chain represents the newest organizational development in health care, but there is little that is uncontroversial about investor-owned chains.

Many believe that superior management resources can be supplied by chains, and they have found great favor with investors, physicians, communities, and governments.

In fact, investor-owned chains are projected to grow at a rate of 20% to 30% per year during the next five years, and they already have begun to enter more difficult markets, as well as going after larger, more sophisticated hospitals, including the management of university teaching hospitals.

In addition, these chains have growth and risk taking as common attributes, although the fields which they tackle and the expectations with which they pursue their business vary considerably.

The second type of multihospital system is the not-for-profit. In this field, a number of Catholic religious orders have made notable progress in bringing their hospital operations under sufficient control so that they, as an order-wide system, can move out and compete for new acquisitions, contract management and opportunities to supply new services. At this stage, the Catholic systems seem most intent on coming to the aid of single Catholic hospitals which, but for a strong sponsor, corporate management, and maybe some cash to get over a bad time, cannot remain viable Catholic hospitals. Whether the Catholic systems will become aggressive competitors for non-Catholic hospitals remains to be seen. They have the talent and resources, but their energy seems to be going into maintaining the Catholic position in the field rather than expanding it.

The Seventh Day Adventists, on the

The multihospital systems and newly corporately reorganized hospitals are much more apt to have the ideas, resources and desire to pursue the new opportunities in the marketplace.

Predicting their likely targets for the next several years is not difficult: they will go where the money is. This is not stated with any intent to denigrate the investor-owned firm; it is merely stating an essential fact for publicly held firms; namely, return on equity, sales, revenues, and the like are important criteria by which businesses enter — and leave.

The investor-owned chain is also more likely to find antitrust laws on their side as they enter new markets, although at the same time, their success in some markets has invited antitrust scrutiny of their mergers and acquisitions.

other hand, represent a religious-operated health service which appears to have rapid expansion goals in operation throughout the United States and other parts of the world.

A third type of system is the local or regional multihospital system. This type of system most nearly resembles the classic, regionalized health system models which have primary, secondary, tertiary and other services closely linked, coordinated, and economically provided to a defined population base. Few of these systems have reached the classical goals set for such systems, but they do find ways to share medical technology, business

systems, purchasing and corporate staff functions. Much research conducted on multihospital systems finds these systems to be more cost effective than single hospitals of comparable size and complexity.

Some other developments in the hospital field deserve attention because they are part and parcel of the developing competitive scene and represent major strategies employed by systems to further their goals.

First, most multihospital systems employ a variety of corporations to carry out their various operations. Single hospitals are beginning to find such multiple corporations useful as well. The label most often applied to this trend is corporate restructuring. The traditional single corporate form has three or four major defects given today's more competitive markets and the nature of reimbursement for hospital services. First, it is difficult for a charitable organization to enter joint ventures with business for profit without endangering its charitable status. By corporately reorganizing, the hospital becomes a subsidiary corporation of a parent and the parent corporation establishes another subsidiary, not a hospital, to work out the joint for-profit ventures.

marketing opportunities to the smaller hospitals so they can compete more effectively with the large, investor-owned hospitals.

Changes in Attitudes and Approaches to Health Care Delivery

How do the perspective and values set of the new systems differ from traditional views of community hospital leaderships? The new commerce of health care seeks to serve communities as much as the old forms, but with a new twist. They focus more on consumers (and physicians are prime consumers of hospital services). They also look very hard at the financial implications, choosing to serve first those markets with the highest rate of return.

This new business mode of thinking will see government moves to reduce reimbursement. The aggressive business-oriented system also will strive to have any and all of the latest technology. The new role is to make the hospital into a successful business; the old role was a mixture of philanthropy, business, governmental surrogate for indigent care, and a place for prominent citizens to

consumers. This movement is already underway.

Hospitals will continue to be very responsive to physicians, but they will be looking for opportunities to work with physicians in a variety of new ventures. With their more flexible corporate forms, joint ventures with physicians can be arranged more easily. But whatever forms are developed, there are likely to be competing ideals and organizations. While such a competitive field may appear to spell trouble for traditional approaches to practice, we now seem to be moving in the logical direction argued for so strongly by those who opposed national health insurance and a fully nationalized health system. Competition is the norm and antitrust law is the only major arbiter of fairness in that kind of system.

Lurking in the background are the big questions of cost effectiveness, quality, accessibility especially for the poor) and comprehensiveness. Will the new approaches be better? More or less costly? Or do we let the marketplace decide? Since the government buys about half of the hospital care delivered in the nation and is therefore the biggest single customer, have they already decided that moving to a market economy in hospital care is the best way to go and that all of medicine should follow? The really big, evaluational questions will be asked only after the system has changed, if at all.

The biggest unknown and most important set of issues however, revolves around how physicians will relate to the new types of organizations being developed. Since no health service worth naming can or will operate without physicians, it seems clear that many choices will be presented for selection by physicians as to how, when, and under what circumstances they will work. Entrepreneurs will develop many schemes to attract medical manpower. Hospitals and hospital systems will want to work closely with physicians, but they also will be taking a harder look at the financial growth and competitive flexibility.

Hospitals will continue to be responsive to physicians, but they will be looking for opportunities to work with them in new ventures.

The corporately restructured hospital now begins to resemble a widely diversified industry with many different health services under corporate forms (for-profit, real estate holding companies etc.). This new flexibility can be extremely important in a fast-moving competitive environment.

A second type of development among hospitals is the national organizations which seek to bring corporate planning, management expertise, purchasing power and

contribute to the civic or religious enterprise.

Implications

The easy-to-predict changes include those which already have occurred in dentistry and law — namely, specialized or general service outlets located in high consumer traffic flow areas. The main test for such services will not be whether or not they meet the expectations of the rest of the medical profession (except on quality) but whether or not they meet those of

continued on page 624



**When does
two
equal
four?**

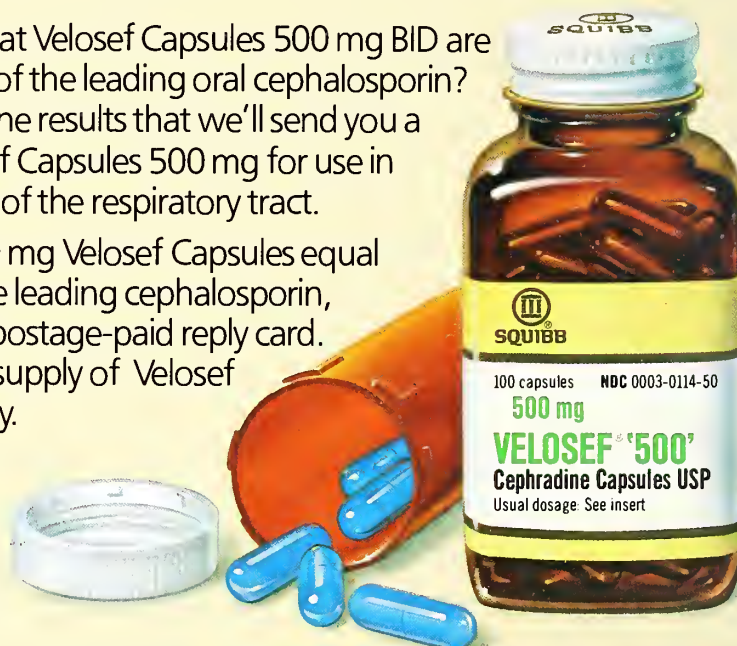


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INDICATIONS AND USAGE: These preparations are indicated for the treatment of infections caused by susceptible strains of designated microorganisms as follows: Respiratory Tract Infections (e.g., tonsillitis, pharyngitis, and lobar pneumonia) due to *S. pneumoniae* (formerly *D. pneumoniae*) and group A beta-hemolytic streptococci (penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever; Velosef (Cephadrine, Squibb) is generally effective in the eradication of streptococci from the nasopharynx; substantial data establishing the efficacy of Velosef in the subsequent prevention of rheumatic fever are not available at present); Otitis Media due to group A beta-hemolytic streptococci, *H. influenzae*, staphylococci, and

S. pneumoniae, Skin and Skin Structures Infections due to staphylococci and beta-hemolytic streptococci; Urinary Tract Infections, including prostatitis, due to *E. coli*, *P. mirabilis*, *Klebsiella* species, and enterococci (*S. faecalis*).

Note: Culture and susceptibility tests should be initiated prior to and during therapy.

CONTRAINDICATIONS: In patients with known hypersensitivity to the cephalosporin group of antibiotics.

WARNINGS: Use cephalosporin derivatives with great caution in penicillin-sensitive patients since there is clinical and laboratory evidence of partial cross-allergenicity of the two groups of antibiotics; there are instances of reactions to both drug classes (including anaphylaxis after parenteral use). In persons who have demonstrated some form of allergy, particularly to drugs, use antibiotics, including cephadrine, cautiously and only when absolutely necessary.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use. Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro*. Mild cases of colitis may respond to drug discontinuance alone. Manage moderate to severe cases with fluid, electrolyte and protein supplementation as indicated. Oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis.

produced by *C. difficile* when the colitis is severe or is not relieved by drug discontinuance; consider other causes of colitis.

PRECAUTIONS: General: Follow patients carefully to detect any side effects or unusual manifestations of drug idiosyncrasy. If a hypersensitivity reaction occurs, discontinue the drug and treat the patient with the usual agents, e.g., pressor amines, antihistamines, or corticosteroids. Administer cephradine with caution in the presence of markedly impaired renal function. In patients with known or suspected renal impairment, make careful clinical observation and appropriate laboratory studies prior to and during therapy as cephradine accumulates in the serum and tissues. See package insert for information on treatment of patients with impaired renal function. Prescribe cephradine with caution in individuals with a history of gastrointestinal disease, particularly colitis. Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. Take appropriate measures should superinfection occur during therapy. Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

Information for Patients: Caution diabetic patients that false results may occur with urine glucose tests (see PRECAUTIONS, Drug/Laboratory Test Interactions). Advise the patient to comply with the full course of therapy even if he begins to feel better and to take a missed dose as soon as possible. Tell the patient he may take this medication with food or milk since G.I. upset may be a factor in compliance with the dosage regimen. The patient should report current use of any medicines and should be cautioned not to take other medications unless the physician knows and approves of their use (see PRECAUTIONS, Drug Interactions).

Laboratory Tests: In patients with known or suspected renal impairment, it is advisable to monitor renal function.

Drug Interactions: When administered concurrently, the following drugs may interact with cephalosporins:

Other antibacterial agents — Bacteriostats may interfere with the bactericidal action of cephalosporins in acute infection; other agents, e.g., aminoglycosides, colistin, polymyxins, vancomycin, may increase the possibility of nephrotoxicity.

Diuretics (potent "loop diuretics," e.g., furosemide and ethacrynic acid) — Enhanced possibility for renal toxicity.

Probenecid — Increased and prolonged blood levels of cephalosporins, resulting in increased risk of nephrotoxicity.

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(continued on next page)

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Investor-owned vs. Not-for-profit

By Robert B. Irvine

Investor-owned multihospital systems have experienced spectacular growth within the last 20 years because of the high quality health care and benefits they provide to physicians, nurses, their patients and the communities they serve. Their strong orientation toward quality and cost effectiveness, coupled with access to capital markets, is likely to cause an increasing number of physicians to practice medicine at these hospitals in the future. Unfortunately, because of unusual reimbursement policies created by Blue Cross/Blue Shield in Ohio, it seems unlikely that Ohio will share in these advantages and growth potential.

Many types of multihospital systems have been formed because of the advantages they enjoy. These systems are owned by religious or charitable organizations, publicly held corporations, and investor-owned corporations. Many have been formed recently by nonprofit groups after the advantages were demonstrated by the remarkable growth of investor-owned hospital systems like Humana Inc. During the period from 1976 to 1981, investor-owned hospital companies increased their total number of owned or managed beds worldwide to over 121,740 and their total number of owned or managed hospitals to over 940. In the United States, investor-owned hospital companies increased their total beds by over 45% and the total number of hospitals by 48%. The

continued on next page

By Charles D. Mross

It has been projected from several sources that 70%-80% of the hospital beds in the United States will be part of a multiinstitutional system by 1990.^{1,2} The incentives for moving toward a multiinstitutional environment have been researched by many authors.^{3,4} The various pressures which the health care industry is facing include those coming from the economy, regulations, changing technology, human resources, capital formation, and the reimbursement mechanisms. These pressures will undoubtedly continue to grow. Two key strategic questions which the independent hospital must ask itself are:

1) Should the hospital proactively become part of a multiinstitutional system and reap the benefits of such a system while it is financially stable and organizationally strong?

2) Will the hospital wait around until its financial performance is jeopardizing its survival and be forced into a decision under undesirable conditions?

The not-for-profit hospital that becomes part of a multiinstitutional system can contribute to the following long-term benefits for its service area:

1) The maintenance of the philosophy of the voluntary health care system;

2) The retention at a local level of the decision-making authority for the development and implementation of health care delivery in its service area;

3) For the local medical staffs, the

continued on page 623

Investor-owned: the pros, the cons

industry expects to continue this growth, although it may not be quite as spectacular as during the past decade.

The distinction between multihospital systems is primarily a matter of tax status. Investor-owned hospitals like Humana pay taxes, while other types of hospitals and hospital systems pay no taxes or are subsidized by taxes, either directly or through the services they receive, without paying taxes to support them.

Investor-owned hospitals often are dubbed "proprietary" hospitals, which is indicative of the misconception that only investor-owned systems earn a profit. For all hospitals, there must be enough money left after expenses to meet the costs of inflation, to improve services, to ensure raises and secure pensions for employees, to replace equipment and facilities, and to plan for the future.

Being a "not-for-profit" enterprise does not mean that a hospital does not need a "surplus" to fill its financial requirements. The differences blur as both types of systems work to make money to fill their needs and ultimately to provide high quality health care in the present and future. In addition to their taxable status, investor-owned systems are more likely to emphasize efficient use of resources — manpower, working capital and facilities.

MEETING PHYSICIANS' NEEDS

Investor-owned hospitals, to compete successfully for physicians' referrals, must provide medical services and technology that are at the forefront with other hospitals in the same service area.

Larger systems have the advantage of sharing technological advances and testing them with less financial risk than a freestanding or small system-owned hospital. Using their financial resources and the expertise of professionals, investor-owned hospitals keep abreast of the latest technologies — like digital radiography — and can provide physicians with modern, innovative, and cost-saving

equipment and procedures for the examination and treatment of their patients. Humana hospitals are unique among investor-owned hospitals in that they also offer their physicians and patients measurable quality goals.

Periodic quality audits assure that hospitals are in compliance with these strict goals. These goals establish guidelines such that the patient will be treated promptly and properly and also reduce cost by lessening error and waste.

NURSING SERVICES

Because of the nationwide shortage, nurses themselves are also a key element in the effective operation of hospitals. A nursing career with an investor-owned multihospital system has many advantages. Nurses may transfer to other hospitals in a nationwide network while maintaining seniority and benefits, or move into the corporate management structure. Additionally, a Mobile Nurse Corps may be established to supply company hospitals with needed additional nurses during temporary periods of unusually high occupancy.

Using corporate revenue, investor-owned systems are in a better position to fund in-service education and reimburse tuition for nurses who desire to obtain additional, job-related education and training. Ongoing training of employees is critical in maintaining excellence in hospital care.

COST EFFECTIVE PATIENT SERVICES

The emphasis on providing and maintaining high productivity and quality health care tailored to the needs of its patients is responsible for the success of investor-owned multihospital systems. Today, investor-owned hospitals provide over 121,700 beds (up 13% from 1980 to 1981) for patients worldwide.

Care provided by investor-owned multihospital systems is priced competitively with other system-owned and freestanding hospitals.

To further contain both costs and charges, investor-owned hospitals now offer to their customers many outpatient services that traditionally were available only on an inpatient basis.

For a multihospital system, patient

satisfaction is important.

CORPORATE ADVANTAGES

Investor-owned multihospital systems are aided by strong financial advantages uniquely available to large corporations. A freestanding hospital or system without financial expertise often is restricted to traditional financing in a limited, local market and may not be able to obtain money as successfully. When expansion is needed, the community often is faced with a bond issue or fund raising campaign.

Traditional financing for other types of systems will become more difficult as Reaganomics take hold. A number of nonprofit and tax-supported hospitals are feeling the economic pinch of inflation and high interest rates. Many are having to consider selling or closing their hospital doors.

In addition to access to sources of capital, multihospital systems also have the advantages of being large-scale purchasers, which result in cost-saving national contracts with suppliers. Additional cost efficiency is achieved by having full-time hospital construction specialists, centrally computerized communication systems, sophisticated marketing programs, and internal auditors. The large scale of investor-owned systems also means that initial temporary revenue losses at one hospital can be offset by profits at other hospitals until the hospital reaches the break-even point.

COMMUNITY ADVANTAGES

Because investor-owned hospitals pay federal and state income taxes, property taxes, and occupational license taxes, they actually help fund other community hospitals and patients on subsidized health care plans and thus aid price competition in the health field which ultimately benefits consumers. Investor-owned hospitals are built and maintained at no cost or risk to taxpayers. This money helps support those consumers who could not afford to pay the costs of their health care.

By providing high quality health care, a stable source of employment and an additional source of local taxes, investor-owned hospital systems help

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*Hannemann, R. E., Erb, R. J., Stoltman, W. P., Bronson, E. C., Williams, E. J., Long, R. A., Hull, J. H. and Starbuck, R. R.: Digital Plethysmography For Assessing Erythrityl Tetranitrate Bioavailability. Clin Pharmacol and Ther 29:35-39, 1981.

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Not-for-profit: the pros, the cons

enhancement of the continuing medical education programs, the establishment of specialty-oriented referral patterns for those specialties not available in the immediate service area, and an overall confidence in the local health care delivery system;

4) Most importantly, the development of a more comprehensive health care delivery system provided in a cost-effective manner while maintaining a desirable level of choice in the way health care is provided.

A recent study by Lewin & Associates⁵ points out several key contributions which multiinstitutional systems and the not-for-profit arena contribute to the overall health care delivery system.

These include:

1) Not-for-profit systems have a higher concern for the social goals of increasing the accessibility and comprehensiveness of services available to the residents of their communities where the for-profit systems tend to place emphasis in pursuing financial growth strategies.

2) In comparison to the for-profit systems, not-for-profit systems tend to expand vertically. This philosophy allows for the integration of health care services which contribute to the development of patient care referral networks which offer a comprehensive range of patient care services.

3) The for-profit systems have been reluctant to offer "unbundled" management services.

4) Within the regions they serve, the not-for-profit systems express the goal of working with the community to provide for all the health care needs of the population. In contrast, for-profit hospital systems have adopted strategies specializing in particular services.

5) "Community involvement" and "assuming responsibility for caring for the health care of the community" are at the core of the not-for-profit hospitals' mission statements. A primary goal, therefore, is the preservation of the values of the not-for-profit, voluntary sector of the health care industry.

In addition:

1) The study could not substantiate the claim that for-profit hospitals run their operations at a greater efficiency than the not-for-profits.

2) The costs per stay in the for-profit hospitals were not lower than the not-for-profit hospitals.

3) The study points out that "costs per day were higher and charges per day or per stay were substantially higher in the for-profit hospitals." In fact, overall charges per day for the for-profit hospitals in the study were 23% higher than the not-for-profit hospitals.

It should be emphasized, however, that since the study looked at a limited sample, these findings cannot be generalized to all hospitals. There is, however, positive financial and service performance being accomplished by the not-for-profit hospital systems that may be more desirable to the consumers of hospital care.

The growth of the not-for-profit systems will continue, contributing to the development of a competitive arena.

The established not-for-profit hospital systems have established themselves in a competitive position to assist smaller and troubled hospitals in the area of capital formation, accounts receivable, cash management, purchasing, physician recruitment, and a whole host of services which the smaller institution cannot afford to form adequately on its own. Through this effort, these not-for-profit systems then have built regional networks of health care services and facilities to include hospital clinics, long-term care facilities and other health services businesses. This, in turn, has allowed the systems to assure that the patients receive the most appropriate level of care in a cost-effective manner.⁶

The not-for-profit systems have moved substantially into the contract management field. Here, the system

through a contractual relationship with another hospital, manages the hospital on the part of the local board of trustees. It should be pointed out that the local board of trustees continue to make the policy-related decisions under this arrangement.

A rather disturbing, but expected trend continues within the for-profit systems' development where consolidation is taking place through acquisition and merger. This type of consolidation, however, will place even greater emphasis on continued growth and financial performance as a primary function of the for-profit corporations.

The growth of the not-for-profit health care systems will continue. This growth will contribute to the development of a highly competitive arena for the not-for-profit systems to challenge the for-profit systems in providing a wide range of services and opportunities to freestanding health care institutions. Boards of Trustees will have to address the question of how to provide for the health care needs of their communities while improving the economic efficiency and financial performance of the hospitals they are entrusted to lead. It will be recognized that the not-for-profit systems will significantly benefit the public through:

1) Managing competitively priced and efficiently delivered health care services.

2) Developing top managerial talents.

3) Benefiting from the key elements of a "system," including financial, human resources, and productivity control.

4) Providing for recapitalization of aging plants through various capital formation capabilities.

5) Retaining the "return on" and "return of" capital in furthering the health care needs of the community.

6) Maintaining the high level quality of patient care that has been provided through the voluntary not-for-profit health care system.

Charles D. Mross is Vice President of MedAmerica.

References for this article are on page 624

Not-for-profit: the pros, the cons

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The New Corporate Hospitals (continued)

Truly, the times have changed. The institutional frame of reference for the practice of medicine crumbles before our very eyes. Yet the nature of medical education, research, and practice provide the average physician with very little knowledge or skill base to assess and stay ahead of the changes. Certainly the nature of practice leaves little time and virtually no in-house resources for the strategic assessment, so important when looking at major market shifts. But the assessment and positive planning and action must be done or medical practice will drift along tides created by others.

Montague Brown is President of Strategic Management Services, Inc.

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Business Interest

Why big business has entered the health-care arena

By Robert E. Holcomb

The history of big corporations illustrates what competitors do when overproduction or excess capacity exists. When this occurs, the major activities are consolidation by acquisition or merger and integration managed by a central structure. A pattern of these activities has been described by Alfred D. Chandler, Jr., in his book **Strategy and Structure**.

Mr. Chandler states that, historically, the primary stimulus that caused businesses in the same industry to combine to form associations or cartels was excess capacity. Later, these combinations consolidated to develop new legal and administrative structures to provide for centralized coordination and for planning for the extended operations and personnel. This "horizontal" consolidation of firms in the same industry permitted these expanded companies to concentrate production in fewer locations, thus providing a higher output at a lower cost.

These new manufacturing firms eventually found it no longer safe to rely on outside wholesale agents who also sold goods of competitors. Because the interest of the agents differed from those of the manufacturers, these new firms could not build their own special markets effectively. This led to their "forward integration," or the development of their own wholesaling and retailing enterprises. Some even set up their own purchasing organizations to obtain raw materials or took over the actual production of them.

Finally, these "vertically" integrated firms evolved into multidivisional

structures from the need to diversify to provide products for different industries. Decentralization became the management theme and corporate offices appeared on the scene to provide corporate strategic planning and allocations.

Jeff Goldsmith compares this pattern to hospital corporate reorganization in his book **Can Hospitals Survive?** He sees that the initial phase of industry growth has occurred among hospitals, and now horizontal consolidation and vertical integration are taking place. "Approximately 30% of the nation's hospitals are now part of multihospital systems, a form of corporate organization that was virtually nonexistent 15 years ago."

Over the last 15 years, the health care industry has begun its own evolution.

At the same time, hospitals are developing their own distribution (feeder) networks and, in some cases, procurement systems for their scarcest resource, health professionals. Over the last 15 years, the health care industry has begun its own evolution from one of the country's last cottage industries into new forms of corporate organization which, both structurally and managerially, resemble those structures Chandler studied in the manufacturing sector of the U.S. economy.

At this stage of their evolution, hospitals are being compelled by market pressures to reexamine their structures and missions as well as their management philosophy. In the Chandler pattern, the hospital industry is in the middle of the first phase of industry evolution — the period of resource accumulation and market control. Some of its larger corporate actors already are entering the period of rationalization resources and enhancement of productivity. Following Chandler's outline, there will be a period of "shaking out" within the industry, during which time those institutions that can develop flexibility, responsive management structures and the control systems needed to render their services price-competitive will consolidate their control over the hospital market."

In recent interviews, executives of four large Ohio corporations did not perceive themselves as knowledgeable enough to project the impact of the hospital corporate reorganization, whether it be on the new health planning coalitions, medical education or medical research. They defer to those in the hospital system industry. However, when reorganization is presented in economic terms such as a "portfolio investment" or a "shrinking market," these men have something meaningful to say about the development of multihospital systems and their effect on large corporations.

First, a new opportunity for investment is being provided. On February 2, 1982, in the **Wall Street Journal**, a full-page advertisement by Owens-Illinois ran as follows:

Improving Our Returns

One of our key financial objectives is to achieve an earnings growth rate which will exceed the average of American industry, either through acquisition or internal growth. Toward this end, O-I recently acquired an interest in Health Group Inc., a newly formed hospital management company. We have made an investment of \$13-million, with options to acquire up to 50% of the company.

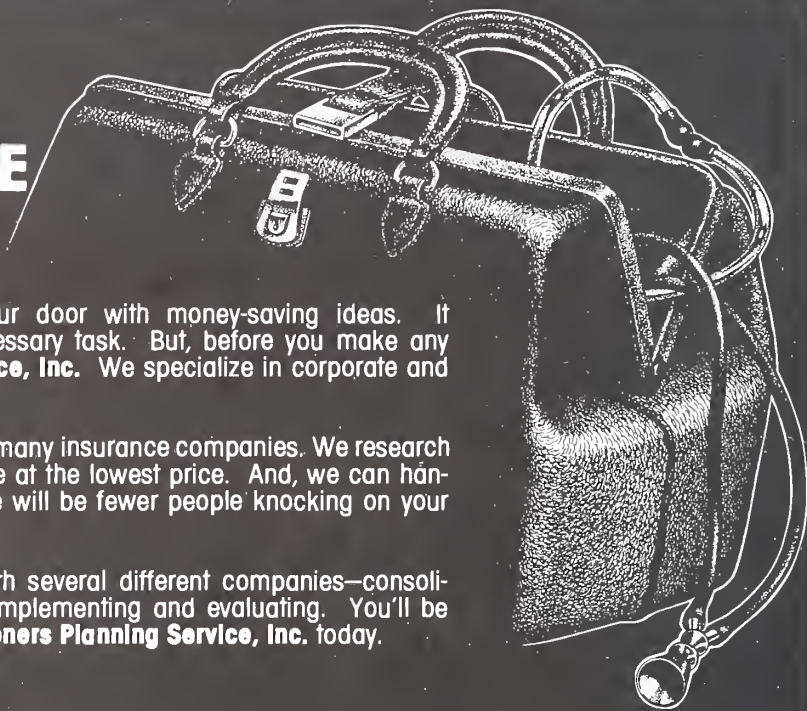
Health Group has already acquired several hospitals in the Southeast and Southwest, and will continue to grow rapidly through an aggressive program to acquire additional facilities. In the last 5 years earnings per share of companies in this industry have grown 33% per year, and ROE's have earned 18%.

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Asked what prompted this investment, Mr. William Buckley, Director, Healthcare Services Operations, Owens-Illinois, stated that like other large corporations, his company has ongoing investment strategy studies. Not only does it compare the growth rate of its businesses to that of other industries, but it also studies the need for new or improved products in its own industry. Owens-Illinois, looking for positive investments over the next 15-20 years, compared its health care businesses and the health care industry as a whole to other industries such as energy and financial services, both of which are expected to do well. It was noteworthy to them that the health care industry consumed approximately \$285 billion in 1981, a tremendous sum of money for an industry.

Management of health facilities and health care services are projected by the Owens-Illinois strategists to have above average growth over the next 20 years, and population, economic growth, nonunion movement, and a favorable regulatory atmosphere in the southeast and southwest provide a positive environment for a good return on investment.

Because Owens-Illinois is a for-profit company, it chose to invest in a for-profit multihospital system, for these systems' acquisition of hospitals, hospital management, and return on equity have been rewarded both in the marketplace and on the bottom line, the profit-and-loss statement. "They represent the ability to cope with excess capacity and a market that is shrinking," commented Bill Jones, Group Healthcare, Owens-Illinois.

A second advantage of a company like Owens-Illinois' diversification into the health care field is illustrated by the above-mentioned newspaper ad which further stated, "We feel this investment not only complements several of our existing businesses, but will also allow us to gain greater insight into the health care business. This in turn, will help us develop new and improved products for this fast-growing industry."

In the present "shake out" period of

a shrinking market, there is accumulation of resources through acquisitions, mergers and management contracts. Market control and stabilization of capacity are the results.

The businessmen interviewed also see in the restructuring of hospital systems the opportunity for the application of many of the same business principles which are followed in their companies. Both James McElwain, Assistant Vice-President of Compensation and Benefits, and Doug Bartlett, National Director of Employee Benefits, U.S., of National Cash Register (NCR) feel the use of both business principles and medical criteria are necessary to achieve successful results. As for business principles,

"The corporate executive who is a hospital trustee must be educated to be a businessman first, then a trustee . . ."

"The corporate executive who is a hospital trustee must be educated to be a businessman first, then a trustee," stated McElwain. If an institution has an established open-heart surgery program with a low mortality rate, why does another hospital have to have a similar program simply for the sake of having the program? Also, should not the hospital trustees be held accountable if the new program were an unnecessary high-cost center and had a mortality rate four times greater?

Bartlett added that more standards are needed to judge hospital operations. Chief executives in industry are held accountable for the return on the firm's investments. So should hospitals be judged by established medical and business criteria.

What has happened in the last 10 years is no indicator of what will happen in the next 10 as corporations

integrate. Bartlett explained that the traditional roles have reversed for the third party and big corporations. NCR now self-insures for its health benefits and Prudential is contracted for the administration. Companies like NCR are collecting data, and in the future, with the help of physicians, they will apply the data to design and pay for health benefits.

Goodyear Tire and Rubber executive, Frank Armstrong, Manager, Health Service Relations, discussed the problem of rising health care costs in relation to his company's payment of employee health benefits. If costs are allowed to continue to rise at the present 15% annual rate, the company's viability as an employer can only diminish, and this, in turn, affects both the individual employee's job and the livelihood of the community in general. Armstrong sees that although health planning has certainly caused hospitals to develop strategic planning and marketing, it has not led to the desired cost containment. He sees a need for closer communication between hospitals and employers as they attempt to determine 10-year outlooks, and his company, like NCR, is looking closely at HMOs and Preferred Provider Organizations (PPO) as alternative systems which may offer their employees quality care at prices the company can "live with."

Also discussing the failure of health planning to contain costs was D.I. Lowry, Senior Vice-President of the Procter and Gamble Company. Though Lowry credits health planning with avoiding the investment of dollars in unnecessary expansion, he sees more possibilities for cost containment in the reorganization of hospital systems. An enlightened management applying sound business practices will impose controls on itself for, as in any other business, if unneeded services are provided, the marketplace starves them out.

A final yet very important aspect of hospital reorganization which these businessmen saw is the increased access to capital. Neither the for-profit nor the not-for-profit hospitals and their systems can construct buildings

continued on page 631

HYPERTENSION:



METHYLDOPA? RESERPINE? INDERAL? COUNTLESS THOUSANDS WOULD BE BETTER OFF WITH

Today, INDERAL—instead of methyldopa, instead of reserpine.

INDERAL exhibits few of the disturbing side effects of methyldopa and reserpine. Sedation, depression, and impotence are rare.* Tolerance is not likely to occur, as it frequently does with methyldopa. For the vast majority of patients—INDERAL means a step toward improving the quality of life. (INDERAL should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.)*

INDERAL blocks beta-receptor sites *in the heart* to reduce heart rate and cardiac output—reducing cardiac work load—sparing an overburdened heart.

Hypertensive hearts can rest easy with INDERAL. For many—it is ideal, first-step therapy.

INDERAL—the sooner, the better for hypertension—a leading risk factor in coronary heart disease.¹

INDERAL[®]

(PROPRANOLOL HCl) B.I.D.

The sooner, the better.



*Please see following page for Brief Summary of Prescribing Information.



Robert C. Winslow, M.D.

“When I first heard the phrase ‘corporate reorganization’, I asked ‘What’s that?’ From then, it has been a learning experience . . .”

The Physician as Entrepreneur

By Robert E. Holcomb

When Miami Valley Hospital in Dayton brought the idea of multihospital systems before their Board, this OB-GYN, a trustee member, suddenly found himself in a position as entrepreneur.

MedAmerica Health Systems is a new multihospital system created by Miami Valley Hospital in Dayton, Ohio. It has gained both statewide and national attention since the announcement of its formation in February 1982 because of its fast growth.

MedAmerica has been described as a "parent corporation, acting as an intermediary between Miami Valley Hospital and three other corporations which include MedAmerica Management Services, a nonprovider holding company; the Miami Valley Health Foundation, with philanthropy mandates; and MediShare, a taxable corporation which delivers other services."

This system is a charter member of Voluntary Hospitals of America which is composed of the 31 largest health

organizations in the country. Presently, the following Ohio hospitals utilize services of MedAmerica: Dettmer Hospital, Troy; Piqua Memorial Hospital, Piqua; Stouder Memorial Hospital, Troy; Akron General Medical Center, Akron; Hocking Valley Community Hospital, Logan; Fayette County Memorial Hospital, Washington Court House; Greenfield Area Medical Center, Greenfield; Clinton Memorial Hospital, Wilmington; Crestview Nursing Home, Dayton; Wilson Memorial Hospital, Sidney; and Community Hospital of Springfield and Clark County, Springfield.

Robert C. Winslow, M.D., served on the MVH Board of Trustees for seven years. During four of those years he was chief of staff-elect and chief of staff, and served when the Board

studied and decided to create MedAmerica. He has practiced obstetrics and gynecology since 1967 in Dayton and is in a three-man group. The following is an interview with him on the MVH reorganization.

OSMA JOURNAL: What was the principal reason for Miami Valley Hospital (MVH) to reorganize?

DR. WINSLOW: Capital protection is essential for the hospital today and the one basic benefit from a multihospital system is access to more capital. Some of the other main reasons for reorganization are the costly government regulations which affect operations, the need to shelter assets to avoid capital erosion and the need to account for our services to receive better reimbursement for actual costs.

OSMA JOURNAL: How did you go

about making the decision?

DR. WINSLOW: The Board of Trustees of the hospital began studying this proposition almost four years ago. I was a member of the Board at the time and when I first heard the phrase "corporate reorganization," I asked "What's that?" From then it has been a learning experience. We attended seminars and national hospital-sponsored meetings. We interviewed law firms from San Francisco, Philadelphia and Chicago as well as consultants, to hear their views on reorganization. We had guest speakers and programs on national trends for hospitals and health care for the medical staff. The medical staff was kept informed all along. At the beginning and at the end of our study, we were encouraged that reorganization was the right thing to do.

OSMA JOURNAL: What were the disadvantages?

DR. WINSLOW: It costs something and it is a paper shuffle. A lot of money was spent on legal fees and consultant time. The Board members themselves gave a great amount of time to this element because it is a corporate issue and not a medical activity. There was the risk of misconception by the nominal owners of the hospital, the Miami Valley Hospital Society. It could have been a problem if it were thought they were losing their hospital to a giant structure. You run the risk of jeopardizing the tax-free status of the hospital, if not executed appropriately. Our concern was with the image in the medical community as well as in the public sector. There was the risk of being perceived our purpose was to become a business-oriented corporation or a nonprovider business. Our goal is not to have parking lots or an apple farm. We don't want to offset reimbursement from Blue Cross with apples. Our basic mission is to deliver health care and to engage in activities that enhance that role. We are a service, not a business enterprise. But you cannot run a service organization in Dayton in 1982 without being a business. Getting over the hurdle of image was very important.

OSMA JOURNAL: Did the Board consider going to a for-profit status?

DR. WINSLOW: No. Our basic concept was to remain a not-for-profit institution. We did want to adjust ourselves so we could have spin-offs that could have nonprovider activities. It's like having a gift shop. You do make some money and the funds are used to support the primary goal by buying items for the hospital that enhance the ability to serve the patients. This is the purpose of these new companies.

OSMA JOURNAL: Is not reorganization a competitive action with impact on the other area hospitals?

DR. WINSLOW: The Board of Trustees realized that MVH was virtually the only large hospital in the area that was a freestanding acute-care institution. All others were affiliated with a national organization such as the Seventh Day Adventist or the Catholic systems. Even though we have reorganized, our hospital is autonomous. This means the Board's constituency is still the public and not an organized church or higher body. There's always competition but we were playing catch-up. Corporate reorganization has put us in a more competitive position. The other hospitals have had greater buying power because their national organizations could help them. We have formed a network and saw that formation advantageous for our hospital. There has not been the usual outcry of condemnation when you do something in the city.

OSMA JOURNAL: What were the principal objections by the medical staff?

DR. WINSLOW: We tried to keep the staff informed all along. There was no organized opposition. If you asked what didn't they like about it, they usually asked, "Now what are they doing?" But when explained they usually said, "Oh." They didn't always understand the reasons. It took me a year to begin to understand terms like low-cost base center reimbursement; but when we presented the element in a rational way, it was met with general approval. The overall scene of hospital and

health care in the U.S. has been a major component in our discussions. We have had seminars and have brought guest speakers in to bring the medical community and Board up to date on national developments. I think our medical staff is the most educated staff in the area on the subject. Our docs certainly understand what an HMO is, who Humana is, etc. They know what it means to have PruCare put in primary-care clinics all over town and what it does to the hospital and the health care system. We, the Board and the administration, are committed to strengthening private practice. Whether it means expanding the referral base for specialists at the hospital, or by having access to patients in other communities by means of an outreach concept or by contract with a hospital, these activities are to enhance the private practice.

OSMA JOURNAL: Will you provide facilities for outreach?

DR. WINSLOW: We don't have a large market where the hospital is located. Also, the population has shifted to the suburbs. To respond to the change in demographics of our city, you have to put primary-care physicians where the people are. The hospital has converted a house it has owned into an office building. It is rented to physicians on a fee-per-hour basis for use as a satellite office. He can use his own nurse or have the hospital provide one. The office will be maintained by the hospital, but it will bring the physician to the market area. It is hoped patients will be referred to MVH but it is not required.

OSMA JOURNAL: One of the hospitals which you manage is now merging with the hospital across town from it. Was this anticipated?

DR. WINSLOW: We believe the merger of the hospitals in Troy was necessary a few years ago. After Dettmer Hospital was contracted for management services, both the Boards of Dettmer and Stouder were approached and offered assistance to merge. Twenty years ago it made sense to have hospitals situated eight miles apart because there was lots of money then. Today it's like running a small neighborhood grocery store next

to Kroger's. You can't do it today and survive. Even though we have provided assistance, the local people must decide to have partial consolidation or total merger. It's what they want.

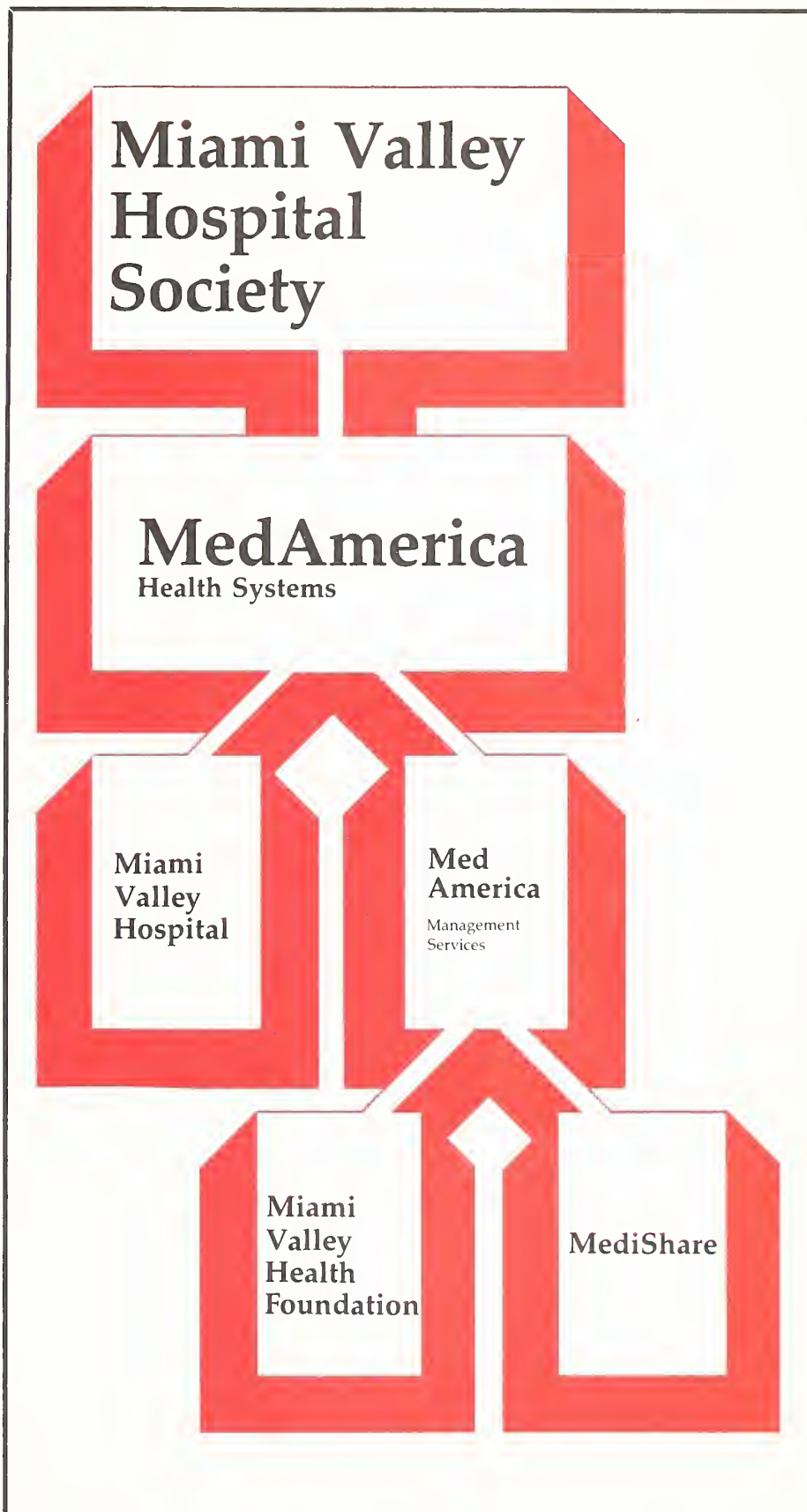
OSMA JOURNAL: Is consolidation and reorganization the wave of the future?

DR. WINSLOW: Consolidation into a larger operation and contracting with a management system are occurring nationally. I think they will continue to occur. In 10 years, I believe the independent, freestanding hospital will be an anachronism. It will become part of a larger network. You do have the choice to stand still and be pared away until you have nothing left. You can become a nursing home or an alcohol rehab center, or you can expand to provide services to other hospitals that would be pared anyway. Our corporate goal is to reach out.

OSMA JOURNAL: What advice would you offer to other physicians?

DR. WINSLOW: Not every hospital needs to restructure. The small hospital should acquire services from larger ones if that meets its need. Unless the reorganization increases the viability of the institution, restructuring probably is not going to be helpful.

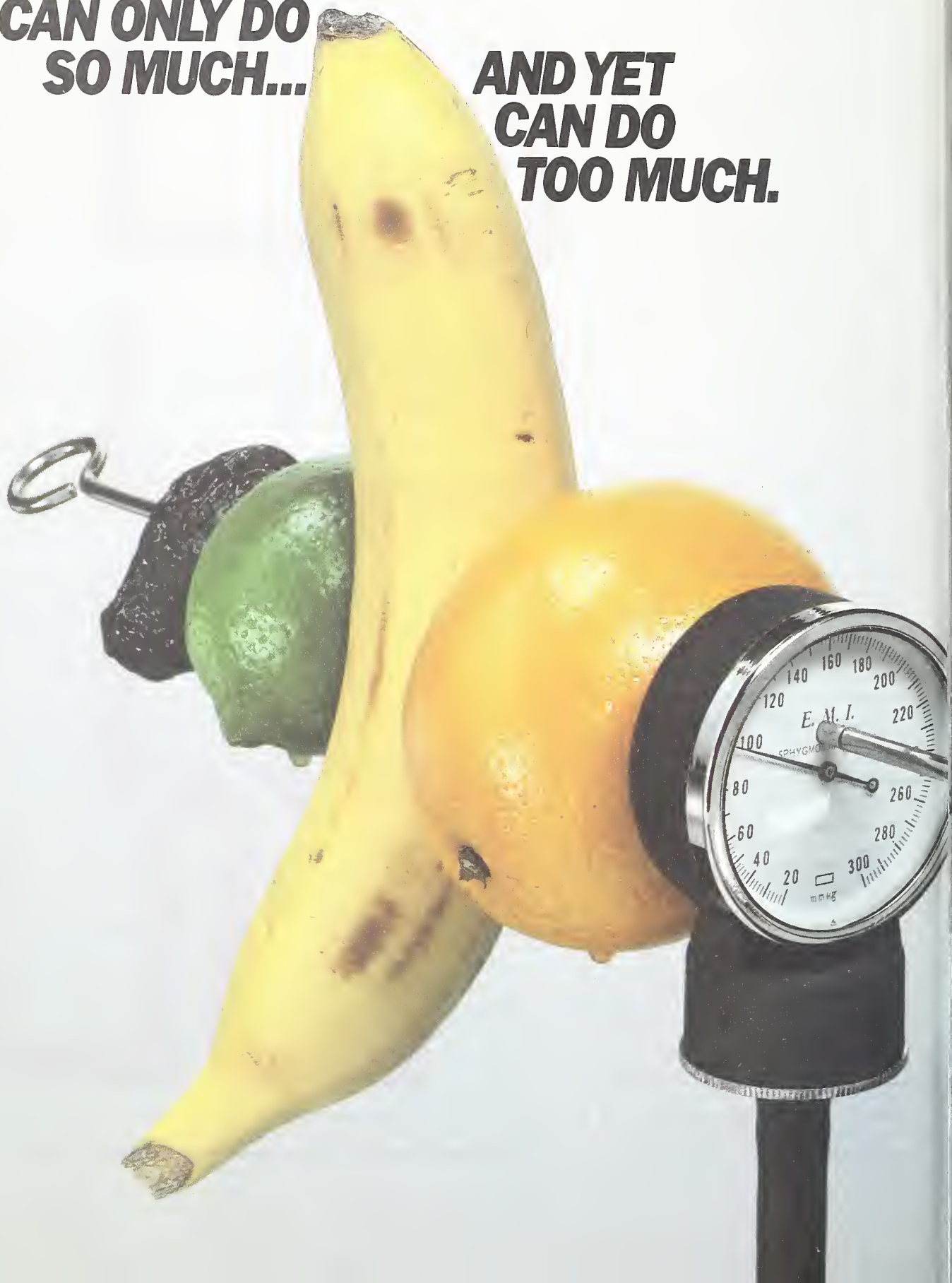
Do get the best professional advice from consultants and attorneys, but it doesn't have to be reorganization attorneys. Considering reorganization is a learning process to clearly understand the pros and cons for your institution. It is not a faddish thing. The important element is the difficult times ahead for corporate finance of any hospital, especially the small ones. They will most likely be involved with some chain.



At right: The structure, formed by the Miami Valley Hospital, is detailed in this organizational chart.

**BECAUSE
A THIAZIDE ALONE
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80/25**

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BRIEF SUMMARY
(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

INDERIDE®	No. 484—Each INDERIDE® 40/25 tablet contains	
BRAND OF	Propranolol hydrochloride (INDERAL®)	40 mg
propranolol hydrochloride	Hydrochlorothiazide	25 mg
(INDERAL®)	No. 488—Each INDERIDE® 80/25 tablet contains:	
and hydrochlorothiazide	Propranolol hydrochloride (INDERAL®)	80 mg
	Hydrochlorothiazide	25 mg

WARNING: This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

INDICATION: **INDERIDE** is indicated in the management of hypertension (See boxed warning.)

CONTRAINDICATIONS: **Propranolol hydrochloride (INDERAL®):** Propranolol hydrochloride is contraindicated in: 1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol, 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS: **Propranolol hydrochloride (INDERAL®):** **CARDIAC FAILURE:** Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn; b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of propranolol therapy. Therefore, when discontinuation of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levalterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

USE IN PREGNANCY: Propranolol hydrochloride (INDERAL®): The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in

animal studies at doses about 10 times the maximum recommended human dose.

Hydrochlorothiazide: Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers: Thiazides appear in breast milk. If the use of the drug is deemed essential, the patient should stop nursing.

PRECAUTIONS: Propranolol hydrochloride (INDERAL®): Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncope, attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely: hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause are: dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements such as foods with a high potassium content.

Any chloride deficit is generally mild, and usually does not require specific treatment except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather. Appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice. Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

ADVERSE REACTIONS: Propranolol hydrochloride (INDERAL®): **Cardiovascular** bradycardia, congestive heart failure, intensification of AV block; hypotension; paresthesia of hands; arterial insufficiency usually of the Raynaud type; thrombocytopenic purpura.

Central Nervous System: lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Miscellaneous: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

Hydrochlorothiazide: **Gastrointestinal:** anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

Central Nervous System: dizziness, vertigo, paresthesias, headache, xanthopsia.

Hematologic: leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular: orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: purpura, photosensitivity, rash, urticaria, necrotizing angitis (vasculitis, cutaneous vasculitis), fever, respiratory distress including pneumonitis, anaphylactic reactions.

Other: hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

HOW SUPPLIED: — Each hexagonal-shaped, off-white, scored **INDERIDE** 40/25 tablet is embossed with an "I" and imprinted with "INDERIDE 40/25"; contains 40 mg propranolol hydrochloride (**INDERAL®**) and 25 mg hydrochlorothiazide, in bottles of 100 (NDC 0046-0484-81) and 1,000 (NDC 0046-0484-91). Also in unit dose package of 100 (NDC 0046-0484-99).

— Each hexagonal-shaped, off-white, scored **INDERIDE** 80/25 tablet is embossed with an "I" and imprinted with "INDERIDE 80/25"; contains 80 mg propranolol hydrochloride (**INDERAL®**) and 25 mg hydrochlorothiazide, in bottles of 100 (NDC 0046-0488-81) and 1,000 (NDC 0046-0488-91). Also in unit dose package of 100 (NDC 0046-0488-99).

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Store at room temperature (approximately 25° C).

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New York, N.Y. 10017

7996/882

Report on the Examination of Financial Statements for the Years Ended December 31, 1981 and 1980

ACCOUNTANTS' REPORT

The Committee on Auditing and Appropriations
Ohio State Medical Association
Columbus, Ohio

We have examined the balance sheets of Ohio State Medical Association at December 31, 1981 and 1980 and the related statements of operations and undesignated net worth and changes in financial position for the years then ended. Our examinations were made in accordance with generally accepted auditing standards and, accordingly, included such tests of the

accounting records and such other auditing procedures as we considered necessary in the circumstances.

In our opinion, the aforementioned financial statements present fairly the financial position of the Ohio State Medical Association at December 31, 1981 and 1980 and the results of its operations and changes in financial position for the years then ended, in conformity with generally accepted accounting principles applied on a consistent basis.

Columbus, Ohio
February 19, 1982

Coopers & Lybrand

OHIO STATE MEDICAL ASSOCIATION BALANCE SHEET, December 31, 1981 and 1980

ASSETS

	1981	1980
Current assets:		
Cash and cash equivalents	\$1,511,247	\$1,052,857
Accounts receivable, net - regular	123,100	90,032
Accounts receivable, PICO	69,315	
Prepaid expenses	29,867	35,573
Total current assets	1,733,529	1,178,462
Other assets:		
Restricted funds for designated purposes (Note 10)	339,539	304,811
Mortgage note receivable (Note 5)	59,461	
Investments:		
General Trust Fund, at cost which approximates market	55,580	48,881
Physicians Insurance Company of Ohio (PICO), at cost (Notes 7 and 8)	100,000	100,000
622 South High Street, Inc. (Note 5)	24,233	
Real estate (land — \$43,775, building — \$41,225) (Note 5)		85,000
Prepaid conversion costs on computer installation, net of \$36,438 amortization in 1981 (Note 1)	24,292	36,438
	603,105	575,130
Property and equipment, at cost (Notes 1 and 2):		
Building	569,390	531,776
Data processing equipment	111,714	111,714
Furniture, fixtures and equipment	127,453	110,796
	808,557	754,286
Less accumulated depreciation	(232,054)	(183,397)

	576,503	570,889
Land	289,113	289,113
Deposit on data processing equipment	23,381	
	888,997	860,002
	<u>\$3,225,631</u>	<u>\$2,613,594</u>

The accompanying notes are an integral part of the financial statements.

OHIO STATE MEDICAL ASSOCIATION BALANCE SHEET, December 31, 1981 and 1980

LIABILITIES AND NET WORTH

	1981	1980
Current liabilities:		
Accounts payable	\$ 148,621	\$ 114,666
Installment payable, real estate investment (Note 5)		42,500
Current portion, term debt (Note 2)	27,632	25,527
Other current liabilities	608,318	475,241
Total current liabilities	<u>784,571</u>	<u>657,934</u>
 Term debt (Note 2)	 <u>118,520</u>	 <u>146,098</u>
 Deferred income:		
Annual membership dues (Note 1)	295,408	211,048
Life membership dues (Note 1)	38,100	40,200
Other	3,555	
	<u>337,063</u>	<u>251,248</u>
 Net worth (Notes 6 and 9):		
Designated funds (Note 10)	339,539	304,811
Undesignated funds	1,645,938	1,253,503
	<u>1,985,477</u>	<u>1,558,314</u>
	<u>\$3,225,631</u>	<u>\$2,613,594</u>

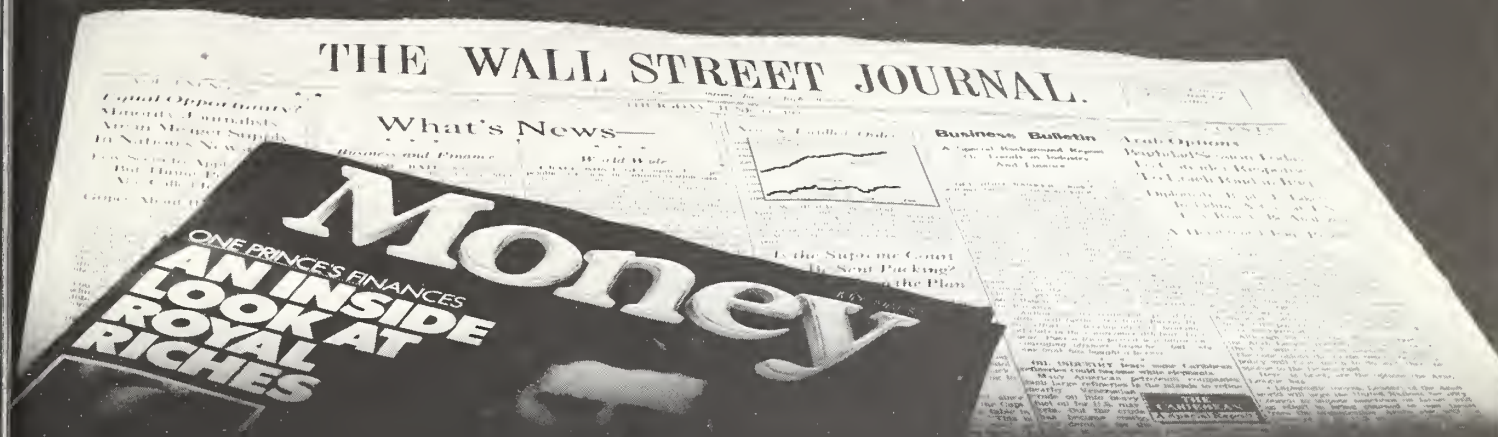
The accompanying notes are an integral part of the financial statements.

STATEMENT OF OPERATIONS AND UNDESIGNATED NET WORTH for the years ended December 31, 1981 and 1980

	1981	1980
Income:		
Membership dues (Note 1)	\$2,155,876	\$1,795,523
Exhibit fees	8,200	5,750
Annual meeting	21,704	20,880
Fees for collection of AMA dues	9,262	8,597
CME accreditation and courses	2,229	6,098
Ohio State Medical Journal (Note 6)	127,678	119,374
Interest	301,990	186,928
General trust income	6,699	4,869
Administration and technical service	50,000	50,000
Rental income	24,045	14,936
Promotion and development	109,750	
Other	67,678	56,421
	<u>2,885,111</u>	<u>2,269,376</u>

continued on page 644

ACCORDING TO THE WALL STREET JOURNAL AND MONEY MAGAZINE...



An entirely new breed of life insurance called Universal Life (available now from PICO Life as PICO Lifestyle I) is . . .

"One of the highest tax-deferred . . . or tax-free . . . yields on your savings"

"Could be one of the best tax shelters around"

"A flexible, do-it-yourself combination of life insurance and a high-interest savings account, arranged and rearranged to match changing responsibilities and ability to pay premiums"

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Contact PICO Life to find out why people who usually are not excited about life insurance are very excited about this new concept in flexible financial planning.

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Bares Drive, P.O. Box 281, Pickerington, Ohio 43147
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Famous Pairs.

They work so well together.

One of man's most amazing explorations and scientific adventures, the successful Gemini flight program was a triumph of imagination and—teamwork. Two men learned to operate in space, to rendezvous, to dock, and to work outside their spacecraft in the hard vacuum of outer space. Not only did they coordinate their efforts with ground backup, they also complemented each other's activities within the close confines of the space capsule.

Anusol-HC[®] & Tucks[®]

...another well-known pair that works so well together! Ninety-five percent of colon/rectal surgeons surveyed* added Tucks pads concomitantly to hemorrhoidal treatment programs they recommended.



Anusol-HC[®] Suppositories / Cream with Hydrocortisone Acetate

The #1 physician-prescribed product for hemorrhoids and other common anorectal disorders**

- ☐ Antiinflammatory, to relieve edema, burning, itching, pain
- ☐ Astringent, to help promote healing
- ☐ Emollient, for easier bowel movements and soothing relief of local trauma

And, when pain is a special problem, Anusol Ointment offers the benefits of the anesthetic, pramoxine HCl.

TUCKS[®] Pre-Moistened Hemorrhoidal / Vaginal Pads

The #1 hemorrhoidal pad* for added external relief and gentle cleansing of fecal residue

- ☐ Soothes, cools, comforts the irritation and itch of hemorrhoids and other common anorectal disorders
- ☐ Hygienic rectal wipe—an integral part of the anorectal regimen

Once pain and inflammation subside, for dual action recommend regular ANUSOL[®]—to maintain patient comfort—and TUCKS[®]—to maintain patient anorectal hygiene.

ANUSOL-HC[®] Suppositories / ANUSOL-HC[®] Cream

Before prescribing, please see full prescribing information. A Brief Summary follows:

Indications and Usage:

Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in external and internal hemorrhoids, proctitis, papillitis, cryptitis, and fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol[®] Suppositories or Ointment.

CONTRAINDICATIONS

Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

WARNINGS

The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

PRECAUTIONS

General

Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.

Pregnancy

See "WARNINGS"

Pediatric Use

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

DOSAGE AND ADMINISTRATION

Anusol-HC Suppositories—Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

Store between 59°-86°F (15°-30°C)

1089G010

PARKE-DAVIS

Warner-Lambert Company
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**WARNER
LAMBERT**

* Meeting of Am Soc Colon/Rectal Surgeons, May 1980.

** Based on total prescriptions filled for hemorrhoidal preparations during the first three quarters of 1981. The National Prescription Audit, IMS America Ltd, Sept 1981.

* 1981 data from leading marketing research organization.

Departmental operating expenses:		
Administration	389,135	342,447
Education and meeting management	314,986	257,087
Health education	91,141	102,198
Field service	123,066	78,657
Fiscal and membership	321,665	283,155
Government relations	178,324	148,639
Communications	546,263	450,820
Organization services	208,872	158,134
State and federal legislation	283,229	227,618
	<u>2,456,681</u>	<u>2,048,755</u>
Income from operations before equity in loss of subsidiary	428,430	220,621
Equity in loss of subsidiary (Note 5)	(1,267)	
Net income from operations for the year	427,163	220,621
Undesignated net worth, beginning of year	\$1,253,503	\$1,337,693
Transfer to designated funds (Note 10)	(34,728)	(304,811)
Undesignated net worth, end of year	<u>\$1,645,938</u>	<u>\$1,253,503</u>

The accompanying notes are an integral part of the financial statements.

STATEMENT OF CHANGES IN FINANCIAL POSITION for the years ended December 31, 1981 and 1980

	1981	1980
Source of funds:		
From operations:		
Net income	\$427,163	\$ 220,621
Depreciation and amortization not requiring working capital	60,803	58,578
Increase (decrease) in deferred income (net of \$2,100 amortization of life memberships)	85,815	(39,087)
Additional long-term indebtedness		99,310
Decrease in investment in real estate	85,000	
	<u>658,781</u>	<u>339,422</u>
Application of funds:		
Acquisition of property and equipment, net	77,652	26,119
Investment in real estate		85,000
Investment in 622 South High Street, Inc.	24,233	
Increase (decrease) in General Trust Fund	6,699	(131)
Repayment of term debt, net of conversions to current	27,578	111,028
Funds restricted for designated purposes	34,728	304,811
Mortgage note receivable	59,461	
	<u>230,351</u>	<u>526,827</u>
Increase (decrease) in working capital	<u>\$428,430</u>	<u>\$(187,405)</u>
Changes in the components of working capital:		
Increase (decrease) in current assets:		
Cash	\$458,390	\$(153,484)
Accounts receivable	102,383	39,620
Prepaid expense and unamortized costs	(5,706)	13,532
	<u>555,067</u>	<u>(100,332)</u>

Increase (decrease) in current liabilities:

Accounts payable	33,955	22,639
Current portion, term debt	2,105	3,978
Installment payable, real estate investment	(42,500)	42,500
Other current liabilities	133,077	17,956
	<u>126,637</u>	<u>87,073</u>
Increase (decrease) in working capital	\$428,430	\$(187,405)

The accompanying notes are an integral part of the financial statements.

NOTES TO THE FINANCIAL STATEMENTS

1. Accounting Policies:

The following is a summary of certain significant accounting policies followed in the preparation of the financial statements. The policies conform to generally accepted accounting principles and have been consistently applied.

a. Depreciation:

Depreciation and amortization are recognized on the straight-line method in amounts adequate to amortize costs over the estimated useful lives of the assets as follows:

Buildings	40 years
Data processing equipment	5 years
Furniture, fixtures and equipment	10 years
Prepaid conversion costs on computer installation	5 years

Depreciation and amortization charged to operations amounted to \$60,803 in 1981 and \$58,578 in 1980.

b. Deferred Membership Dues:

Income from annual membership dues is recognized in the calendar year to which they apply. Life membership dues income is recognized over 25 years of active practice of the life membership participants.

2. Term Debt:

Term debt at December 31, 1981 consisted of the following:

8% Mortgage loan payable in monthly installments of \$2,427, including interest, collateralized by land and building, and due July 1, 1984 \$ 63,419

8% Mortgage loan payable in monthly installments of \$500, including interest computed semiannually, collateralized by land and building. OSMA has the right of prepayment of principal not to exceed \$10,000 per annum, noncumulative, for the first five years. After five years, OSMA has an unlimited right of prepayment 71,113

14¼% Commercial note payable in sixty monthly payments of \$360, including interest, collateralized by the equipment purchased, and maturing September 21, 1985. OSMA has the right of prepayment

\$ 11,620
146,152
27,632
\$118,520

Less current portion

Maturities on term debt subject to mandatory redemption are as follows:

1982	\$ 27,632
1983	30,100
1984	15,516
1985	3,252
1986	444
Later years	69,208
	<u>\$146,152</u>

3. Pension Plan:

The Association maintains a trustee noncontributory pension plan for its eligible employees. The funding of the pension plan is through employer payments.

The actuarial cost method used in determining the valuation of funding is the entry-age-normal with frozen-initial-liability method.

The total cost of the plan charged to operations in 1981 and 1980 was \$68,943 and \$73,733, which includes amortization of past service costs over approximately a thirty-year period.

A comparison of accumulated plan benefits and plan net assets at December 31, 1981 is as follows:

	1981	1980
Actuarial present value of accumulated plan benefits	<u>\$742,709</u>	<u>\$772,534</u>
Market value of plan assets available for benefits	<u>\$703,327</u>	<u>\$708,115</u>

The information regarding the actuarial value of nonvested accumulated plan benefits is not available.

OSMA presents a new membership service to save you money.

A bank card plan to improve your cash flow.

The Ohio State Medical Association, in association with The Huntington National Bank, announces a new bank card plan—VISA® or MasterCard™—with benefits for you and your patients.

Speeds cash flow.

Receive immediate credit when your bank card deposits reach The Huntington. Eliminates accounts receivable and reduces bad debts and collection problems. Your bookkeeping is simplified, too.

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OSMA has negotiated a special discount rate of 2.75%, far lower than the regular Huntington discount rate to merchants. Plus there is no fee for installation, supplies, imprinter plate or promotional materials. If you need an imprinter, the cost is only \$25.

Huntington Business Checking Account.

This is the key to your OSMA bank card plan. Most professionals mail in their receipts daily but there are more than 130 Huntington offices statewide for your convenience. Each month you'll receive both a detailed accounting of all of your financial transactions and a "discount advice" which totals all of your bank card transactions for the month.

Normal Huntington Business Checking charges will apply and you can take advantage of other specialized business services, including payroll preparation, record keeping and a full range of cash management services.

Good for your patients, too.

Your patients will appreciate the convenience and the option of extended payments. You improve your cash flow while providing your patients with significant financial advantages.

Questions.

If you have any questions, please call Jerry J. Campbell at our OSMA office (614/228-6971), or Huntington Merchant Services at (614/469-7564).



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ADDRESS _____

CITY/STATE/ZIP _____

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☐ I want to open a Huntington Business Checking Account.

☐ Corporation ☐ Solo Practice
☐ Partnership

☐ I already have a Huntington Business Account at the _____ office.

☐ I need _____ imprinters at \$25 each. The Huntington will deduct the cost from your checking account.

Please Mail To:
Ohio State Medical Association
600 S. High Street
Columbus, Ohio 43215



The assumed investment rate of return used in determining the actuarial present value of accumulated plan benefits was 6.5% for both 1981 and 1980.

4. **Leases:**

The minimum rental commitments of the Association under all noncancelable leases were as follows at December 31, 1981:

	1981	1983	1984
Automobiles	<u>\$59,365</u>	<u>\$34,337</u>	<u>\$9,139</u>

Rental expense under these and similar leases aggregated \$87,506 during 1981 and \$74,617 during 1980.

5. **Investment in 622 South High Street, Inc.:**

During 1981, OSMA formed a corporation to be known as 622 South High Street, Inc., which corporation shall have as its main purpose the ownership and management of property at 622 South High Street, Columbus, Ohio. In exchange for the property which at December 31, 1980 had a book value of \$85,000, the Association received 100% ownership in said corporation (100 shares of common stock at \$255 a share) for \$25,500 and a 10% mortgage note receivable for \$59,500, maturing in 2029, payable in equal monthly installments of \$500.

OSMA accounts for the investment using the equity method.

During 1981:

Original investment in 622 South High Street, Inc. (100 shares)	\$25,500
Loss from operations for the period ended December 31, 1981	(1,267)
Investment in 622 South High Street, Inc. at December 31, 1981	<u>\$24,233</u>

Condensed financial information for 622 South High Street, Inc. is as follows:

Condensed Balance Sheet

	Dec 31, 1981
Assets	\$84,871
Liabilities	<u>60,638</u>
Net Worth	<u>\$24,233</u>

Condensed Statement of Operations

	Period Ended Dec 31, 1981
Rental	\$ 7,258
Expenses	<u>8,525</u>
Net loss	<u>\$(1,267)</u>

6. **Ohio State Medical Journal:**

The income and expenses applicable to the operations of "Ohio State Medical Journal" are as follows:

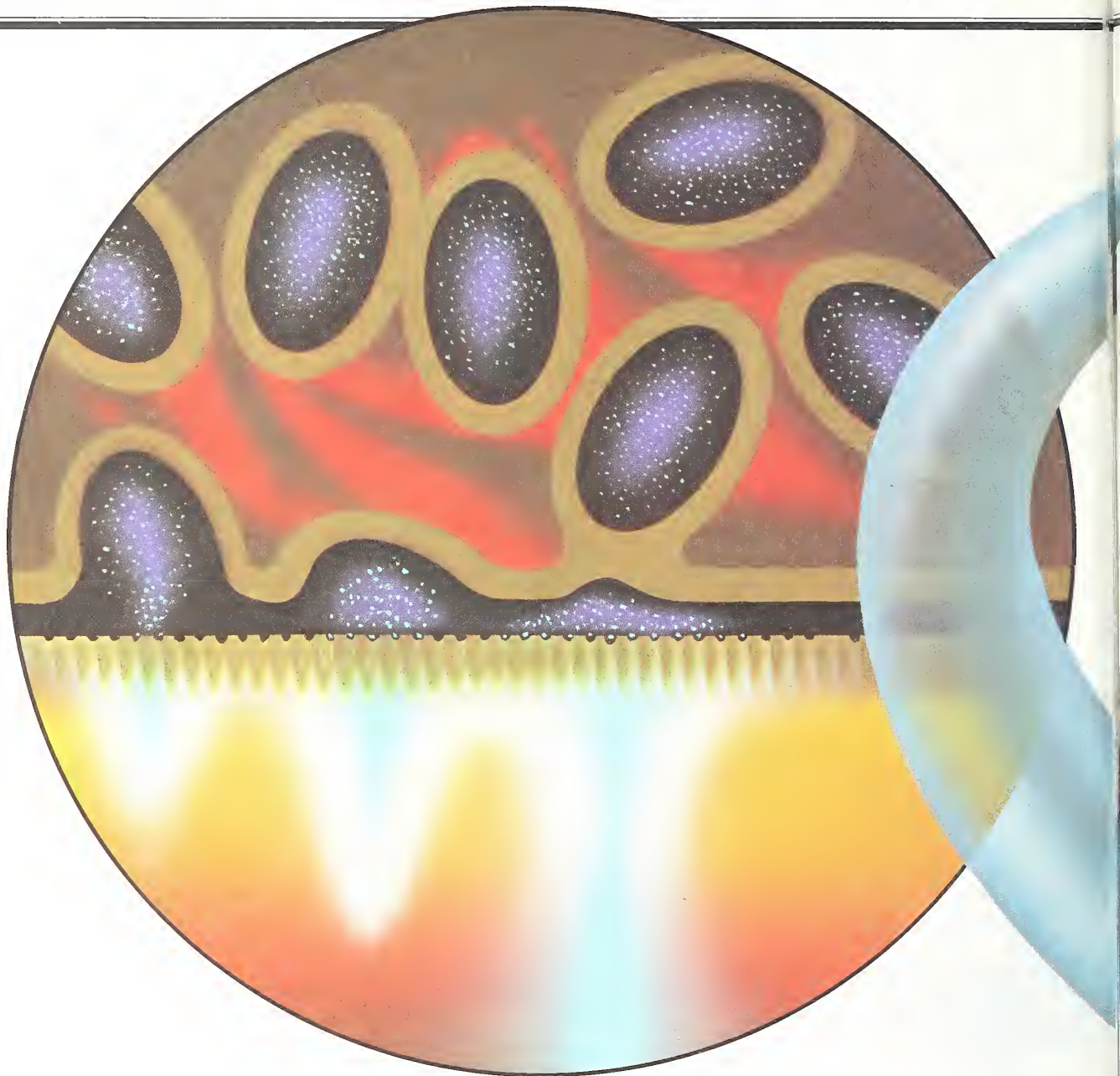
	1981	1980
Income:		
Advertising (net of commissions of \$23,999 in 1981 and \$21,204 in 1980 and cash discounts of \$1,919 in 1981 and \$1,458 in 1980)	\$123,113	\$110,732
Subscriptions received from nonmembers	4,295	8,485
Other	270	157
Membership subscriptions, allocated at \$11.65 for 1981 and \$9.32 for 1980, per dues-paying member (included in membership dues income on the Statement of Operations and Undesignated Net Worth)	<u>178,339</u>	<u>102,883</u>
	<u>306,017</u>	<u>222,257</u>
Expenses:		
Salaries, pension costs, payroll taxes and other employee benefits	113,694	85,567
Printing, postage, stationery, supplies, illustrations, engravings and consulting services	218,044	179,017
Building expenses, depreciation and other	<u>13,053</u>	<u>9,205</u>
	<u>344,791</u>	<u>273,789</u>
Excess of expenses over income, Ohio State Medical Journal	<u>\$ 38,774</u>	<u>\$ 51,532</u>

7. **Investment — Physicians Insurance Company of Ohio:**

The Association owns 100% of the Class B common stock of Physicians Insurance Company of Ohio (PICO). PICO has two classes of common stock, Class A and Class B. Each Class of stock has equal rights on a per share basis to participate in dividends and other types of distributions, whether from earnings or in the nature of dividends. The Association earned \$4,600 dividend income in 1981 and \$3,450 in 1980, which are included in other income in the accompanying financial statements. Each Class A share is entitled to one vote and each Class B share is entitled to 100 votes.

By virtue of its ownership of 100% of the outstanding Class B shares (10,000 shares), the Association is entitled to 1,000,000 votes. At December 31, 1981, the Class A shareholders owned 849,002 shares of Class A stock. Ac-

VALIUM® (diazepam/Roche) IN THE FOREFRONT OF NEURORECEPTOR RESEARCH



Artist's concept of neurotransmitter
being released into synaptic cleft and
impinging on receptor sites



Opening new investigative pathways into where and how Valium (diazepam/Roche) exerts its distinctive antianxiety action

New discoveries in receptor research have stimulated the search for endogenous brain substances that may be involved in the mediation of anxiety.¹⁻⁵ It has been further theorized that these substances may act as ligands that bind to the same or similar sites as do benzodiazepine molecules^{5,6}—binding sites early identified with the use of ³H-diazepam.^{5,7} These binding sites are now postulated to be benzodiazepine receptors, since the ability of benzodiazepines to bind with the sites appears to correlate with their clinical effects.^{2,4,7,8}

Present investigations into clinical relevance of binding sites.

Laboratories at Roche have conducted research to identify and isolate substances that may prove to be endogenous ligands, but no definitive identification has yet been made. Researchers are also studying substances which do not bind, but rather interact with the benzodiazepine binding sites—most notably gamma-aminobutyric acid (GABA)—and are postulated to mediate certain pharmacologic and clinical benzodiazepine effects.^{2-4,9,10}

Under especially intense investigations are the GABA receptors and the benzodiazepine binding sites themselves—apparently constellations of closely linked but not identical structures.⁸

Future implications for improved therapy.

In future work, Roche researchers and other scientists hope to identify and characterize various differential sites in the brain, which may result in more specific diagnostic and therapeutic approaches.

2-mg, 5-mg, 10-mg scored tablets
Valium®
diazepam/Roche
THE RESEARCH AND CLINICAL LEADER

Please see brief summary of product information
and references on the following page.

ROCHE®

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not as sole therapy).

The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

The clearance of Valium and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

Side Effects: Drowsiness, confusion, diplopia, hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice; periodic blood counts and liver function tests advisable during long-term therapy.

Dosage: Individualize for maximum beneficial effect. **Adults:** Anxiety disorders, symptoms of anxiety, 2 to 10 mg b.i.d. to q.i.d.; alcoholism, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; adjunctively in skeletal muscle spasm, 2 to 10 mg t.i.d. or q.i.d.; adjunctively in convulsive disorders, 2 to 10 mg b.i.d. to q.i.d. **Geriatric or debilitated patients:** 2 to 2½ mg, 1 or 2 times daily initially, increasing as needed and tolerated. (See Precautions.) **Children:** 1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use under 6 months).

How Supplied: For oral administration. Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100* and 500; * Prescription Paks of 50, available in trays of 10.† Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25† and in boxes containing 10 strips of 10.†

*Supplied by Roche Products Inc., Manati, Puerto Rico 00701

†Supplied by Roche Laboratories, Division of Hoffmann-La Roche Inc., Nutley, New Jersey 07110

- References:** 1. Tallman JF et al: *Science* 207:274-281, Jan 18, 1980. 2. Bunney WE Jr: *Psychiatr Ann* 11:11-15, Jan 1981. 3. Davis JM et al: *J Clin Psychiatry* 42(11) Sec 2:4-14, Nov 1981. 4. Study RE, Barker JL: *JAMA* 247: 2147-2151, Apr 16, 1982. 5. Braestrup C, Nielsen M, Olsen CE: *Proc Natl Acad Sci USA* 77:2288-2292, Apr 1980. 6. Bosmann HB, Case KR, DiStefano P: *FEBS Lett* 82:368-372, Oct 1977. 7. Braestrup C, Albrechtsen R, Squires RF: *Nature* 269:702-704, Oct 20, 1977. 8. Snyder SH: *Psychosomatics* 22:986-989, Nov 1981. 9. Rickels K: *J Clin Psychiatry* 42(11) Sec 2:40-44, Nov 1981. 10. Haefely WE: *Br J Psychiatry* 133:231-238, Sep 1978.

to create a financial climate that benefits the consumer in their communities. They are an important element in enriching the overall quality of life for its citizens.

THE FUTURE

But will the success of investor-owned multihospital systems continue in the future? Hospital management analysts and consultants suggest that investor-owned hospital corporations will continue to enjoy rapid growth as they have in the past because they serve their customers well and have important competitive advantages.

Investor-owned systems are growing more rapidly than the "not-for-profit" hospital systems, but increased competition is expected from the growing number of multihospital systems which now are adapting the techniques pioneered by investor-owned hospital corporations.

Unfortunately, the growth of investor-owned multihospital systems has been restricted in Ohio. Because of inadequate equity return and reimbursement allowed by Blue Cross/Blue Shield in areas of Ohio, it seems unlikely that physicians and their patients will be able to take advantage of the benefits that investor-owned systems offer in providing high quality hospital care in modern facilities equipped with the latest in hospital technology. Currently, investor-owned multihospital systems own only one hospital of 134 beds in Ohio and manage one other 177-bed hospital.

Perhaps it would be useful for the Ohio medical community to consider some long-range strategic planning. Where will the capital come from to keep their hospitals at the forefront in providing the best in medical care? How can Ohio hospitals be made more cost effective? The experience of investor-owned hospital chains might provide some valuable answers in planning for the future.



ROCHE PRODUCTS INC.
® Manati, Puerto Rico 00701

Financial statements (continued)

cordingly, at December 31, 1981, the Association was entitled to exercise 54.08% of the voting power of PICO. When the total authorized Class A shares (2,000,000) and Class B shares (16,667) have been sold, the Class A shareholders will have 55% of the voting control over PICO.

Physicians Insurance Company of Ohio had a total stockholders' equity of \$14,370,630 at December 31, 1981 and \$12,064,176 at December 31, 1980. The Association's equity in PICO totaled \$164,744 at December 31, 1981 and \$140,444 at December 31, 1980.

8. Insurance Holding Company System:

The insurance holding company system presently consists of two affiliated persons, the Ohio State Medical Association (OSMA) and Physicians Insurance Company of Ohio (PICO).

OSMA controls PICO by virtue of its ownership of 10,000 shares of Class B common stock of PICO, comprising 100% of such outstanding shares of stock (see Note 7).

9. Exemption — Federal Taxes on Income:

The Ohio State Medical Association is exempt from federal

taxes on income under Section 501(c)(6) of the Internal Revenue Code.

10. Restricted Funds for Designated Purposes:

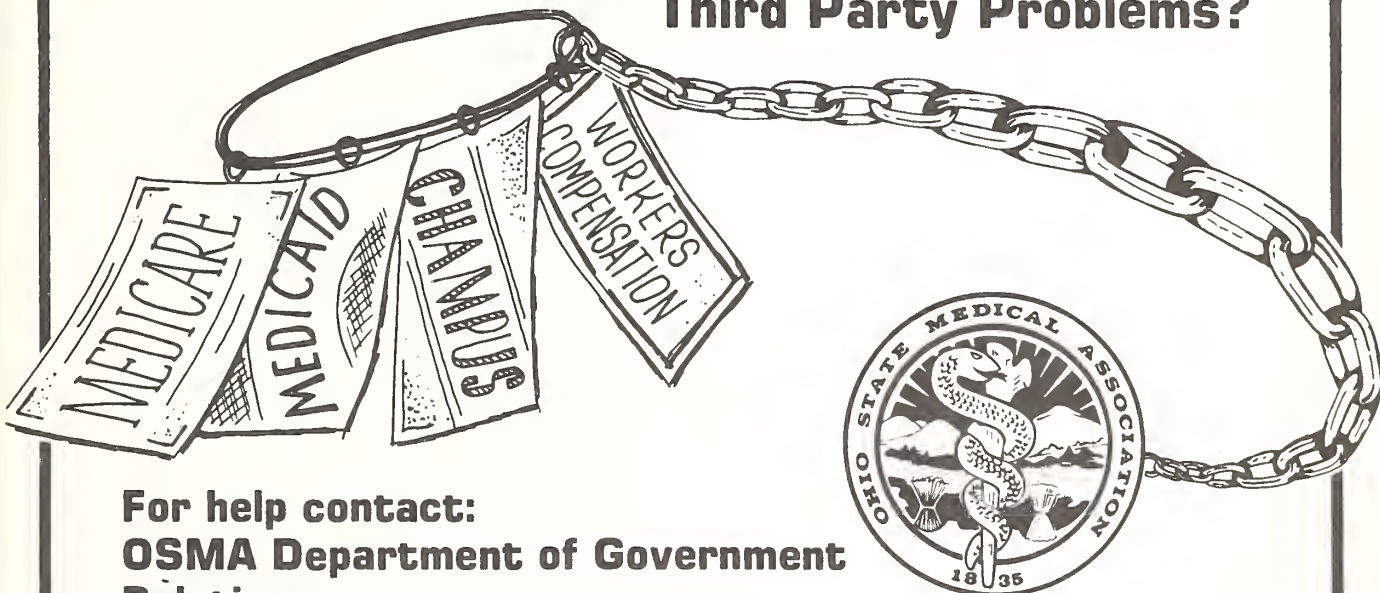
During 1980 and 1981, the Council of the Ohio State Medical Association authorized funds to be restricted for designated purposes. The funds represent cash that has been designated for the following purposes as of December 31, 1981 and 1980:

	1981	1980
Capital Improvements	\$ 59,829	\$111,816
Data Processing	97,645	45,499
Malpractice Research		
Fund	77,135	67,496
Staff Development	104,930	80,000
	<u>\$339,539</u>	<u>\$304,811</u>

11. Reclassification:

Certain amounts previously reported as of December 31, 1980 have been reclassified to conform to current year 1981 classifications.

Third Party Problems?



For help contact:
OSMA Department of Government Relations
614/228-6971

Another Service of Your OSMA

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NEW For the preferred risk Ohio physician market
LOW PICO's **Heritage Plan** line of preferred personal insurance coverages for OSMA members and their families are now available at extremely competitive rates!
RATES
FOR **Heritage Plan** offers you the finest protection available for your automobile, home, and other personal possessions.
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AUTO Because of PICO's many possible rate credits, **your automobile and homeowners' premiums with PICO may be significantly lower than your present coverage rates!** And, if you choose an Auto/Home Package policy, your premiums can be even lower!
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Pickerington, Ohio 43147

(614) 864-7100 or toll free in Ohio 1-800-282-7515

Obituaries

FRANCIS J. HARVEY, M.D.,
Dayton; University of Medicine, Wien,
Wien, Austria, 1922; age 84; died June
22, 1982; member OSMA and AMA.

PATRICK F. HEALEY, M.D.,
Cleveland; Case Western Reserve
University School of Medicine, 1944;
age 64; died July 24, 1982; member
OSMA and AMA.

RUSSELL NICHOLL, M.D.,
Cleveland; University of Rochester
School of Medicine and Dentistry,
1943; age 68; died June 6, 1982;
member OSMA and AMA.

JAMES B. PATTERSON, M.D.,
Columbus; Ohio State University
College of Medicine, 1937; age 70; died
July 26, 1982; member OSMA and
AMA.

DAVID B. RULON, M.D., Baltic;
Duke University School of Medicine,
Durham, 1944; age 60; died April 30,
1982; member OSMA and AMA.

JAMES L. SAWYER, M.D.,
Middletown; University of Cincinnati
College of Medicine, 1951; age 57; died
June 23, 1982; member OSMA and
AMA.

M. DOW SCHOLL, M.D.,
Chillicothe; Ohio State University
College of Medicine, 1924; age 82; died
July 7, 1982; member OSMA and
AMA.

ADOLPH SHOR, M.D., Milford;
University of Cincinnati College of
Medicine, 1941; age 67; died June 1,
1982; member OSMA and AMA.

FRANCIS L. TRACY, M.D.,
Cleveland; University of Ottawa
Faculty of Medicine, 1953; age 63; died
July 2, 1982; member OSMA and
AMA.

50-Year Recipient dies

WILLIAM BOUKALIK, M.D.,
Cleveland; Ohio State University
College of Medicine, 1929; age 81; died
July 7, 1982; member OSMA and
AMA.

Dr. Boukalik served as president of
the Cleveland Academy of Medicine in
1967, and was president of the Ohio
Division of the American Cancer
Society in 1968. A recipient of
distinguished service awards from
both the Cleveland Academy of
Medicine and the American Cancer
Society, Dr. Boukalik had also received
the OSMA's 50-year award. At the
time of his death, Dr. Boukalik was
the medical director of St. Alexis
Hospital.

DONALD E. BRINKMAN, M.D.,
Cincinnati; University of Cincinnati
College of Medicine, 1952; age 56; died
July 4, 1982; member OSMA and
AMA.

AMBROSE H. CLEMENT, M.D.,
Cincinnati; Howard University College
of Medicine, Washington, D.C., 1951;
age 56; died July 2, 1982; member
OSMA and AMA.

RICHARD CUNNINGHAM, M.D.,
Defiance; Case Western Reserve
University School of Medicine, 1939;
age 70; died June 27, 1982; member
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References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease*, op. cit., p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, op. cit., pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med* 89 (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.



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CLINICAL NOTES

Edited by Karen S. Edwards

Oral penicillin and hemorrhagic colitis

Recent cytotoxic assays and special culture techniques have provided evidence in one group of patients with antibiotic-associated diarrhea that overgrowth of *Clostridium difficile* has caused pseudomembranous colitis. This article cites the cases of two patients who developed hemorrhagic colitis, associated with oral therapy with penicillin derivatives. The colitis was characterized by predominant right-sided involvement, sparing of the rectum and distal colon, absence of pseudomembrane formation and presence of marked hemorrhage in the lamina propria.

Although antibiotic diarrhea traditionally has been considered to result from an antibacterial effect on the normal colonic flora, hemorrhagic colitis may be a specific toxic reaction to a structural component of penicillin.

In the two patients studied, bloody diarrhea appeared within a few days and the total dose of penicillin derivatives was 2-5 g. A further illustration of the toxic effect is suggested by a recent report that penicillamine administration was accompanied by hemorrhagic colitis.

Discontinuation of antibiotics resulted in prompt resolution. Early colonoscopy in such cases is recommended. In view of the frequency of oral penicillin

prescriptions worldwide, additional cases seem likely.

—The American Journal of
Gastroenterology
July, 1982, Vol. 77, No. 7; pgs.
491-493

Child abuse

Observations and awareness play a vital part in the effective delivery of health care. In evaluating possible child abuse cases, this point cannot be stressed enough. Factors such as the type of injury vs. alleged method reaction of the parent, reaction of the child, home environment, etc., all play important parts in evaluating the possibility of abuse.

In evaluating injury to the child, the location, size and shape of the injury are important in consideration of abuse. There are some distinguishing factors which separate abusing injury from nonabuse injuries. For example, lesions often are concentrated in clusters on the trunk and buttocks and are morphologically similar to the implements used to inflict trauma. Bleeding into the skin is purpuric and almost never petechial, and is distributed among the abrasions and scratches. Finally, the skin lesions are of different ages. The important questions to remember in physical evaluation of injuries are: Does the child's injury correspond with the reported method of injury? Is the size, shape, etc., similar to an injury of the reported type, or is it possible a weapon was used to inflict injury? Are bruises or cuts in similar or different stages of healing?

Health professionals should familiarize themselves with the different agencies and laws in their area, which relate to the subject of child abuse. The role of the health professional is directed toward gathering information and knowledge of its significance — to be passed on to the hospital or other agency.

—Emergency Medical Services
July/August, 1982; Volume 11, No. 4;
pgs. 63-69

Metoclopramide hydrochloride induced Parkinsonism

Parkinsonism, induced by antipsychotic drugs such as the phenothiazines and butyrophenones, is well known, but little attention has been paid to the parkinsonism evoked by long-term metoclopramide hydrochloride therapy for GI tract disorders.

The clinical characteristics of ten patients with metoclopramide hydrochloride-induced parkinsonism were studied recently. The condition was found to be more common in aged women and developed subacutely with bilateral symptoms. Because it sometimes is accompanied by a rest tremor, it may be confused with Parkinson's disease, and yet it is distinct from the latter in that orolingual dyskinesia and postural tremor often are found before the administration of antiparkinsonian drugs.

Metoclopramide has been used widely in the treatment of levodopa-induced gastric symptoms, which often develop in patients with parkinsonism. It has been reported, however, that metoclopramide, unlike antipsychotic drugs, does not aggravate the symptoms of parkinsonism or affect levodopa-induced dyskinesia. Now it is quite clear that metoclopramide *does* induce parkinsonism, and administration of the drugs used to treat gastric symptoms should be discontinued, when the condition is suspected.

Metoclopramide currently is used frequently and for prolonged periods in internal medicine, but why parkinsonism develops in only some cases is not clear. No predisposition could be deduced by an analysis of patient and family histories.

Patients with metoclopramide-induced parkinsonism may be erroneously diagnosed as suffering from idiopathic Parkinson's disease, and treated with levodopa in vain.

—Archives of Neurology
August, 1982, Vol. 39; No. 6; pgs.
494-496

Arrhythmias

Ventricular tachycardia — is defined as a salvo of three or more consecutive PVCs. This is a grave arrhythmia, indicative of advanced heart disease and a highly unstable rhythm. It develops when an ectopic ventricular pacemaker begins to fire rapidly, controlling the heart rate and causing a marked reduction in cardiac output. This unstable arrhythmia may precipitate acute heart failure, or degenerate into ventricular fibrillation in the presence of ischemia. It resembles a series of PVCs coupled together, and is indicative of a very irritable ventricle.

Ventricular flutter — is a transition arrhythmia, briefly occurring following ventricular tachycardia, and just before it degenerates into ventricular

fibrillation. It is a serious arrhythmia, lasts a few seconds and has the appearance of a sine wave at a rate of 150-300 per minute. There is usually no pulse associated with ventricular flutter.

Ventricular fibrillation — is a life-threatening arrhythmia which will rapidly progress to death if not treated immediately. It is characterized by chaotic electrical activity, and totally disorganized myocardial activity in which there is no cardiac output. Irritable ventricular ectopic foci are depolarizing spontaneously. Often the myocardium is salvageable if the electrical rhythm can be corrected. Most patients will lose consciousness immediately after onset of this arrhythmia. Some may remain conscious for up to 10 seconds before becoming unresponsive. Not infrequently, cardiac arrest due to ventricular fibrillation is heralded by a

hypoxia-induced generalized seizure.
—**Emergency Medical Services**
July/August, 1982, Volume 11, No. 4;
pgs. 72-75

Interview styles and psychiatric symptoms

Self-confident, outgoing, primary care physicians with high, academic ability, tend to make more accurate assessments of patients with psychiatric symptoms, revealed a recent study, involving 45 family practice residents.

Residents were asked to make ratings of the degree of psychiatric disturbances in 30 adult patients. Final results showed that the personality of the physician, his/her interview style and knowledge of medicine were the determining factors in the accuracy of

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CORRECTION

The last two paragraphs were inadvertently omitted from the "Future Investments" article, by Frank Pfaff, Esq., which appeared in the August "Investments" issue. The paragraphs were Mr. Pfaff's concluding remarks, which we print here. We apologize to Mr. Pfaff, and to our readers for any confusion that may have been caused.

CONCLUDING REMARKS - A CAVEAT

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assessments.

Based on videotapes of the resident-patient interviews, investigators were not surprised to learn that those residents who were more self-confident, outgoing, and academically able, were more accurate raters of psychological disorder, as were those who possessed better interview techniques. Those techniques included psychiatric emphasis during the interview (sensitivity to verbal cues, empathic); eye contact with patients; and the use of directive rather than closed questions. Those residents with an accurate concept of psychiatric symptoms can identify correctly the common neurotic symptoms of mental illness, and do not consider that mental illness in family practice is manifested by psychotic symptoms. They are sensitive to nonverbal cues relating to psychiatric illness.

—Archives of General Psychiatry
July, 1982, Vol. 39; pgs. 829-833.

Family practice resource

Family doctors now have a new information resource available to them. The Herb L. Huffington Memorial Library in Kansas City, Missouri was dedicated last month as an information resource center, enabling family physicians across the nation to call a toll-free number and request information on any professional matter from the latest information on diagnosis or therapy to research in progress. It will also serve as a national repository for historical data regarding the specialty of family practice.

Future plans for the facility include: developing a collection of current journals, books and reference materials on family practice; extending the basic reference services beyond the library; and informing family physicians of research in progress. A remote search service is also on the drawing boards.

For more information about the Library, call The American Academy of Family Physicians, 1740 W. 92nd Street, Kansas City, Mo. 64114.

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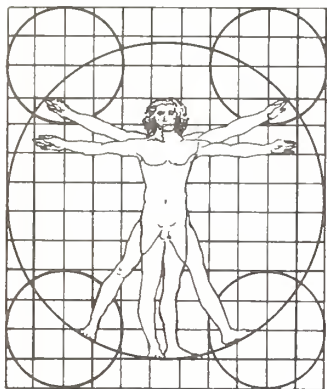
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CLINICAL & SCIENTIFIC

RLF: A NEW LOOK AT AN OLD PROBLEM

Frederick H. Davidorf, M.D.
Esther T. Weiss (By Invitation)

The history of the management of retrolental fibroplasia (RLF) reflects a paradox of modern medicine: improvement of care in one specialty often results in complex problems in another. Thus, the development of O₂ therapy to promote survival in the premature infant has paralleled closely the iatrogeny of RLF. The largest cause of childhood blindness in the United States by 1950, this disease was nearly eradicated in the 1960s because of modifications in O₂ administration. In the past few years, however, technologic advances in the areas of respiratory and nutritional therapy, plus the rise of regional perinatal centers have enabled the medical community to survive a new class of low birth weight infants which formerly were impossible to save. Although the emergence of percutaneous PaO₂ monitoring has increased significantly the ability to administer safe levels of O₂, statistics indicate that RLF again is emerging as a frustrating dilemma for both the pediatrician and ophthalmologist.

The Early History of Perinatal Care and the Emergence of RLF

FROM THE TURN of the century until approximately 1940, the goals of perinatal therapeutics had been twofold: the maintenance of the infant's body temperature combined with proper feeding. This approach changed significantly in the 1940s and 1950s with the emergence of several technologic advances designed to increase survival in the low birth weight infant. One technic was the administration of O₂ as a means to relieve the respiratory distress common in the premature. Several studies were conducted, all resulting in increased survival rates for those infants receiving this form of therapy. O₂ therapy was so successful that by 1948, it was firmly entrenched as a standard form of treatment. Studies showed that an environment of 46% O₂ could be delivered safely for an indefinite period of time, and could be increased to 100% for up to 24 hours.¹ This led to the recommendation by the American Academy of Pediatrics of 40% to 50% O₂ for all premature infants

immediately after birth. This modality was to be continued for a period of 12 hours to one month.²

Although the first case of RLF was identified in 1942,³ many disparate hypotheses existed as to its etiology. Terry believed that the disease was due to the exposure of the immature retina to light. Other hypotheses of cause included viral infection,⁴⁻⁶ vitamin E⁷ and A⁸ deficiencies, and blood transfusions.⁹ None of these early studies considered the effects of O₂ as a cause of RLF, and by 1949, the disease was responsible for 33% of the incidence of blindness in preschool children.¹⁰

The Link With Oxygen Therapy

It was not until approximately 1951 that investigators implicated O₂ therapy as a possible cause of RLF. Even then many conflicting hypotheses emerged. While some believed that exposure to O₂ was the cause of the disease,^{11,12} others thought that, in fact, a lack of O₂ initiated the disease process. In the latter case, both the congenital hypoxia experienced by many premature infants¹³ and that which occurred when the infant was removed from an O₂ environment were blamed.^{13,14} Finally, others still believed that the administration of O₂ was not related to the development of RLF.¹⁵

The controversy surrounding O₂ therapy led to several controlled clinical trials from 1951 to 1954. These studies all implicated the use of O₂ in the development of RLF. The first study conducted by Patz, Hoeck and Delacruz reported a 60% incidence of the disease in infants receiving high levels of O₂, and

Dr. Davidorf, Columbus, Professor, Department of Ophthalmology, Ohio State University.

Ms. Weiss, Columbus, Research Assistant, Ohio State University. This study was made possible by the Snyder Fund, College of Medicine, Ohio State University.

Submitted March 31, 1981.

a 20% incidence in infants who were placed in environments of low levels of O₂.¹⁶ The second study confirmed these findings and concluded that: "RLF is directly related to the excessive administration of O₂ and can be controlled by severely limiting oxygen therapy to premature infants."¹⁷ This study added, "Such restriction does not appear harmful."¹⁷ The third trial warned that "...there was no concentration of O₂ in excess of room air that was not associated with risk of developing RLF."¹⁸ Thus, in just four years, the attitude toward O₂ therapy had progressed from total advocacy and belief in both its effectiveness and benignity to extreme caution and belief, not only in a causal relationship to RLF, but in the relative safety of its disuse. Perhaps this change in orthodox thinking with regard to perinatal care is best demonstrated by the classic texts of that time:

"...oxygen content of the incubator need not exceed 60%, although higher concentrations appear to do no harm and may serve to tide the patient over a spell of anoxia." *Pediatrics* (1953)¹⁹

"...for the small premature infants just admitted to the nursery observation in an atmosphere of 40% to 60% for a few hours or days. . ." *Textbook of Pediatrics* (1954)²⁰

"...moist O₂ should be used only in quantities sufficient to relieve cyanosis when it is present. . . administering O₂ only in such amounts and at times as are absolutely necessary for respiratory distress has practically eradicated RLF." *Textbook of Pediatrics* (1959)²¹

Because of new information, gleaned from clinical and animal investigations, which both implicated O₂ therapy in the development of RLF and implied that its curtailment was not deleterious to premature survival, the practice of routine O₂ therapy was radically modified. This modality was employed only sparingly and even then the O₂ levels were reduced greatly. The incidence of RLF decreased dramatically, but what soon became evident was the inverse relationship between the decline of RLF and the rise of perinatal mortality.²² This led to a reevaluation of O₂ therapy with the hope of providing a balance between its life-saving benefits and sight-threatening complications. One result was the recommendation by Holt in 1962 of a 40% level of O₂ in cases when the infant manifests signs of respiratory distress and then only for such a time as deemed necessary by the physician.²³ The development during the 1960s of better O₂ monitoring technics improved the accuracy with which this determination could be made.

Current Incidence of RLF

It would seem that the final chapter of the RLF story should have been written in the 1960s. In fact, the incidence of the disease continued to decline throughout that decade and into the 1970s. Many believed that RLF had all but been eradicated. In recent years, however, we have been impressed with what we believed to be an increasing number of RLF infants who were being referred to the Retina Service at our institution. To verify this hypothesis, we examined the records of premature infants at Children's Hospital to determine the number of cases of active proliferative RLF diagnosed between 1970 and 1980. (All infants, regardless of birth weight, who receive O₂ therapy undergo ophthalmoscopic examination before discharge.) Remarkably, there has been a dramatic increase in the number of such cases since 1976, ranging from a low of zero in 1971, to a high of 34 in 1979 (see figure). This increase has been noted at other institutions as well.

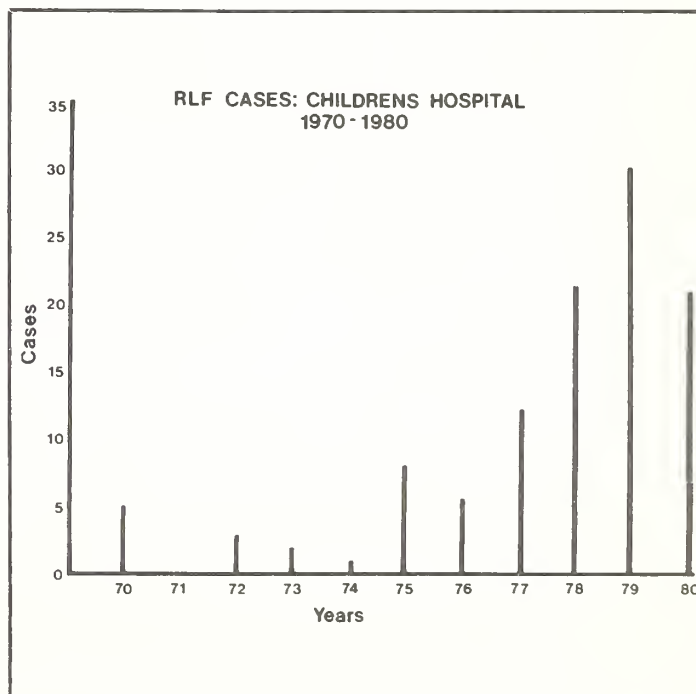
Perinatal Care: Recent Advances

The current rise in the incidence of RLF seems unquestionably linked to recent developments in the area of perinatal care. Success in this area can be shown best by a comparison of survival data. In 1948, Dunham reported no survival in infants

weighing less than 1,000 grams.¹ By 1976, a study by Case Western Reserve University School of Medicine reported that infants weighing 750-1,000 grams had nearly a 50% chance of surviving and, of those weighing more than 1,000 grams, over 80% would survive.²⁴ Even more dramatic were the improved survival rates for infants from this institution when compared between the mid and late 1970s. Between 1973 and 1975, there was a 70% survival rate for those weighing 501-1,000 grams. The overall survival rate for both groups was 57%. During the three-year period between 1976 and 1978, there was an 81% survival rate for infants weighing 1,001-1,500 grams and a 47% rate for those weighing 501-1,000 grams. Overall, the survival rate for both groups was 60%.²⁴

These statistics reflect several developments resulting in improved perinatal care. Among the most important include advances in respiratory and nutritional therapy as well as the emergence of regional perinatal nursery centers. The first ventilators designed specifically for infant use were developed in the early 1970s and provided long-term respiratory support for premature infants suffering from respiratory distress syndrome. Previous attempts at using adult ventilators were unsuccessful because of the infant's much less rigid airway system. Total parenteral nutrition (TPN), although first used as early as 1939, has played a crucial role in premature survival since 1969 when the advantages of the administration of nutrients through a central rather than a peripheral vein were discovered. Throughout the next decade, this refinement became standard practice. Concomitant with this improvement was the increased ability to manage the infant's electrolyte and fluid imbalance. A final factor in the survival of the premature has been the recognition before birth of the high risk infant and the proliferation of regional perinatal centers specializing in the care of the low birth weight infant. All of these developments have provided the best chance for the premature to benefit from the latest technology in perinatal care, thus increasing its chances for survival.

Who are the infants now at risk? As in the 1960s, those infants weighing less than 1,600 grams are at greatest danger. Their numbers, however, have increased dramatically. Although the current treatment available to these patients has



improved, no appreciable success in preventing visual loss has been achieved. Photocoagulation, as well as the advancement in surgical technics such as vitrectomy and scleral buckling procedures, have not improved significantly the visual outcome for those infants whose level of RLF has progressed to the more advanced cicatricial stages. Recent reports do suggest that cryotherapy may be of benefit in some cases, but definitive proof awaits further study.^{25,26}

Percutaneous PaO₂ Monitoring

Perhaps the most important advancement in the prevention of RLF lies in the development since 1978 of the apparatus for continual percutaneous monitoring of the PaO₂ levels in the premature infant and may, in the future, help to control the rising incidence of RLF. Further evaluation of this procedure is required, however, before its true value can be determined.

Despite all of these efforts to prevent the development of RLF in the premature, it is inevitable that the relative hypoxic environment of the infant in utero (PaO₂ levels of 18-25 mm Hg) is altered significantly at birth by the administration of life-saving O₂ which increases the PaO₂ levels to 60-90 mm Hg during the first 24 hours and 50-70 mm Hg thereafter. The effect of such an increase on the immature retinal vessels is not known nor are all of the susceptibility factors which contribute to the development of RLF. The ophthalmologist as well as the pediatrician must realize that RLF, far from being controlled, is again on the rise. The clinical trials conducted in the 1950s concluded that, "There was no concentration of O₂ in excess of room air that was not associated with the risk of developing RLF."¹⁸ This fact is as valid today as it was then. As long as we continue to improve the ability to survive the very low birth weight infant who inherently is in need of O₂ therapy, we will continue to be faced with the problem of RLF.

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Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1981 Subscription: \$15 per year, single copy \$2 (outside U.S. \$20 and \$3).

Send address changes to: The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second Class Postage paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

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SECOND OPINION

An Opinion on Emergency Medicine

By Glenn C. Hamilton, M.D. and Alexander T. Trott, M.D.

Though emergency medicine obtained specialty status in 1979, there continues to be debate as to its validity of "specialization," lifestyle, and in particular, its academic basis. To date, the discussions have been dominated by private practitioners of emergency medicine and/or "traditional" academic specialists. The academic representative of emergency medicine has remained relatively silent. In that light, we offer the following as an academician's reflection on the status and future of our specialty.

PREHOSPITAL CARE

One of the most easily defined areas encompassed by emergency medicine is prehospital care. The growth and development of EMTs and paramedics have paralleled the growth of the specialty. There has been a shared responsibility in developing a practice philosophy that took physician accountability for patient care outside of hospital and office walls and transferred it to the scene of illness or

injury. Through this concept, the "standard of care" in large communities now involves highly trained, well-equipped paramedic squads with telemetry and radio-contact capability based in the emergency department. These squads

The practice of emergency medicine is a unique opportunity to track down undefined disease within the constraints of time.

have demonstrated improved patient care in the field, and are invaluable "eyes and ears" for the practicing emergency physician. Importantly, they are also a source of community awareness, support, and pride in the

entire medical care system. Emergency medicine will continue to play a crucial role in devising and maintaining these matrices, while supporting research aimed at maximizing prehospital care benefits, both in therapeutics and systems analysis.

HOSPITAL CARE - THE PRACTICE

The practice of emergency medicine is a unique opportunity to track down undefined disease within the constraints of time. The challenge is both exhausting and exhilarating, for one must balance the obvious acute disease process with the more subtle potential for significant illness found in the "routine case." The testing of one's clinical diagnostic abilities is a continuous process. The pursuit of disease is based in the traditional model of patient care. A history and physical exam are performed, laboratory studies are ordered and interpreted, therapy and follow-up are offered to virtually every patient. The

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandro-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg. Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg. Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D., R. Witherington, M.D.; I. B. Sipahoglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Private physicians soon realize the emergency department provides a place to send acutely ill patients for treatment and stabilization. This translates into better care for both the acutely ill patient and the patients in the private office . . .

patterns of referral may include return visits to the emergency physician, since a disease's natural history may not be so far developed as to reveal itself. The practice challenges in the emergency department lie in managing this traditional physician-patient interaction on a "new" patient who may or may not be cooperative within a limited time frame. No physician can meet all of the patient's needs, but a skilled emergency physician can stabilize and/or treat a number of them while insuring adequate and well-timed referral.

An example of a practice area upgraded by the appearance of emergency medicine is found in trauma care. Major trauma care has improved as a result of a number of influences: military advances, basic and clinical research, prehospital care development, increased awareness and attention on the part of the surgeon, consumer awareness, government support, and the development of the trauma center. Emergency medicine has contributed to all of these factors. Our field has grown in parallel with major trauma management, and stabilization of the critically injured patient has become the *sine qua non* of emergency medicine. Minor trauma care is managed best where the materials and manpower necessary to handle sprains/strains, fractures, soft tissue injuries and infections are available. Emergency physicians have the interest, training, and materials to care for minor wounds.

In the community hospital, emergency physicians have continued to develop a strong cooperative relationship with other practitioners. Private physicians soon realize the emergency department provides a place to send acutely ill patients for treatment and stabilization. This

translates into better care for both the acutely ill patient and the patients in the private office who do not have to be abandoned because of their physician leaving to handle an emergency problem. Office hours, hospital rounds, and surgery continue, while the acutely ill patient receives an appropriate evaluation and stabilization. The availability of this service continues during the evening, night and weekends.

In the university setting, the addition of a residency program or at least one physician trained in emergency medicine can have a major impact on the delivery of health care and clinical training of house staff.

EDUCATION

In medical schools, emergency medicine has begun by training students as modified emergency medical technicians. These students develop early confidence in the clinical application of the basic sciences toward first aid and basic life support. In the clinical years the third-year students often learn wound care and suture technique under the aegis of emergency medicine, while the fourth-year rotation is a most popular elective. On a graduate medical level, the new residencies are on the cutting edge of educational technique development. These new graduates will change quality and integrity of the field on both a practice and academic level. Rotating services often get their first exposure to acute care under the supervision of emergency medicine. The needs of all practicing physicians in keeping up to date with practical information useful in the acute situation are particularly served by emergency medicine. These demands for postgraduate education have been

well met. All this translates toward a future in which the practical anecdote and literature reviews will be complemented, then supplanted by original research as a basis for practice.

RESEARCH

There are new horizons opening in acute care and outpatient care research. To survey the literature for material on initial, acute, or emergency management is to find often a morass of anecdotal and poorly collected data. Emergency medicine will benefit all practitioners by developing research in the area in which it has the most vested interest, ie, outpatient and acute care. At the same time, there are specific topics in which emergency medicine can develop. Toxicology, environmental injuries, and the field of resuscitation are common ground shared with other specialties, but ground less fallow with the addition of our field.

THE FUTURE OF THE SPECIALTY

We have little doubt that emergency medicine is here to stay. As the field has grown and matured, it has become clear the practice of acute care medicine is an art unto itself. Each field has its acute and emergency problems, but it is impossible to have each specialty available on a moment's notice to manage them. From cardiac arrest to uncontrolled epistaxis, tension pneumothorax to pediatric aspirin ingestion, only the emergency medicine specialist can handle such a broad range so comfortably. The nonacute patient also demands special skills. Most people are brought to the

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Letters to the Editor

(continued from page 670)

ADVANCE divorce

TO THE EDITOR:

Thought you might be interested in hearing of my 52-day "marriage" with the new OMIM "Advance Plan." Our "romance" began on June 21st, 1982, and ended on August 12th, 1982, in a state of complete "divorce." I originally signed the OMIM agreement because I thought their UCR payments would be somewhere near the prevailing UCR payments of other carriers in Northeast Ohio. Wow, was I ever wrong!

My first "UCR" payment from OMIM for routine maternity care and obstetrical delivery arrived on August 12th in an amount 26% less than my Usual charge and also 26% less than I receive from Blue Shield of Northeast Ohio and all other carriers in this area. My **Usual** and **Customary** Fee for the service is based on national and local

charges; the amount is at worst **Reasonable!** I cannot afford to suffer a 26% reduction in my fees so that OMIM can say to its policyholders: "Look what a good deal we have for you on your health insurance!" If OMIM wants to save money and cut costs, why not start with a 26% cut in wages and salaries for all OMIM employees?

Based on my figures at hand, this new "Advance Plan" smells like the biggest rape attempted on the medical profession in Ohio during my quarter century of practice in the State.

It now is obvious to me (I'm basically trusting and naive at first) that the whole Advance Plan program was designed and publicized to intimidate the medical practitioners in Ohio to accept less than current fees for their services under the veiled

threat that to do otherwise might mean collecting nothing at all (from the patient directly). I know of no other insurance arrangement (homeowner, auto, liability, etc.), which places the provider of services in a similar undesirable position. Rest assured, from now on I will take any necessary measures to see that I receive my full reasonable fees for services provided.

I must now accept with great regret the reality of having to fight for my **Usual, Customary, and Reasonable Fees**. Up to this point, I was always within the parameters.

26% less than pleased,
/s/William E. Donze, M.D.



JERRY L. HAMMON, M.D., Dayton, was appointed vice president of medical affairs at Good Samaritan Hospital and Health Center. Dr. Hammon is chairman of the OSMa Committee on Program and Delegate to the OSMa Delegation to AMA.

EARL SMITH, M.D., Shaker Heights, received the Distinguished Service Award from the Cleveland Academy of Medicine. Dr. Smith is emeritus chief of the pediatrics department of Sinai Medical Center and associate clinical professor of pediatrics at Case Western Reserve University's Medical School.

WAYNE C. SMITH, M.D., is the recipient of the Ashland County Healthcare Achievement Award presented by Samaritan Hospital. Dr. Smith was honored for his work outside his private medical practice.

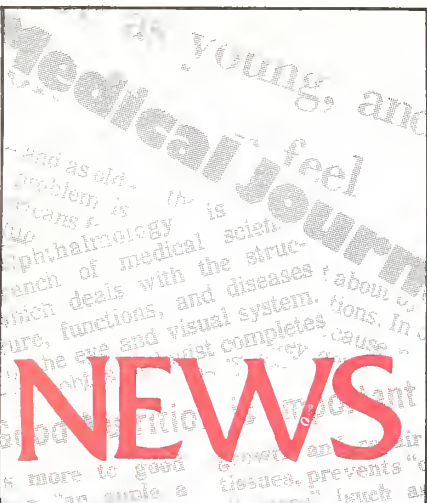
RICHARD J. SOLYN, D.O., was elected president of the Youngstown Society of Obstetricians and Gynecologists. **P.H. HUANG, M.D.,** was elected secretary-treasurer.

ALLEN STRAUS, M.D., West Chester, was appointed medical consultant to the Chemical Dependency Treatment Program at Emerson North psychiatric hospital.

JOHN M. TEW, JR., M.D., Cincinnati, was appointed to the 16-member National Advisory Council of the National Institute of Neurological and Communicative Disorders and Stroke. Dr. Tew is a neurological surgeon and chairman of the Mayfield Center of Surgical Neurology at Good Samaritan Hospital.

ISRAEL WEISBERG, M.D., Cleveland, was appointed medical director for the Cuyahoga County Board of Health Hospice Program.

JEROME WIOT, M.D., Cincinnati, received the Ohio State Radiological Society Award for his contributions to the field. Dr. Wiot is professor and chairman of the University of Cincinnati College of Medicine's Department of Radiology.



a compilation of the latest developments, reports and products of interest to physicians.

**edited by
Gina DiBlasio Cummins**

UC studies pulmonary hypertension.

The University of Cincinnati (UC) will undertake a study on primary pulmonary hypertension, being launched by the National Institutes of Health.

Primary pulmonary hypertension is a rare disease, involving high blood pressure in lung circulation. It tends to be more severe than systemic hypertension because it is rapidly progressive and often leads to death within a few years. Because it is measured internally, it is also harder to recognize.

Although the disease is more common in women than in men, it occurs in people of all ages, and has no known cause or cure. By establishing a patient registry to collect and evaluate patient data on the disease, it is hoped new information on the causes and course of the disease, as well as new methods of treatment, will be suggested.

The UC Medical Center joins 35 medical centers throughout the country in the study. Physicians may contact Dr. Fowler, 872-4721, for additional information, and patient referral.

CAT popularity gives way to other PETT projects.

You've heard about the instant diagnostic abilities of the CAT scan, but how about the value of the PETT (positron emission transaxial tomography) scan?

The sensitivity of PETT imaging and its potential applications are discussed in a recent issue of the *Journal of the American Medical Association*.

"It's good in the sense that a whole host of mental activities can be studied. But it introduces certain problems in that, before these images can be interpreted properly, we're going to have to do a very considerable amount of research on how we can standardize these studies," says Robert Beck, director of the University of Chicago's Franklin McLean Memorial Research Institute.

For PETT scanning to work, radioactively labeled chemicals which are harmlessly incorporated into the brain, first are administered through inhalation or intravenous injection.

The chemicals emit particles called positrons, which collide with electrons in the brain. A computer then calculates the distribution of the positron-electron collisions and produces images that appear as slices of the brain. From these images, physicians can determine metabolic or chemical changes in brain tissue.

Some centers with PETT scanners are studying stroke, trying among other things to gauge how much recovery the patient may expect; epilepsy, in an attempt to identify patients for whom surgery could be of value; and other brain dysfunctions.

Since PETT scanning is a relatively new technological development, its value to the medical field is enormous. "The dilemma really is where to begin because this tool has so many applications," says Malcolm Cooper, M.D., coordinator with Beck of Chicago's PETT project.

Colorectal cancer subject of lectures.

Memorial Sloan-Kettering Cancer Center is sponsoring an accredited Visiting Faculty Program that will give primary care physicians around the country access to the latest clinical information on one of the more prevalent cancers — colorectal cancer.

The program is being presented — without charge — by an independent group of experts in gastrointestinal and family medicine, and is comprised of two parts.

Part I focuses on disease and diagnoses and Part 2 focuses on case findings and management. Each part consists of a lecture supported by slides, a discussion session, and a monograph for independent study and later referral. The Visiting Faculty will address audiences comprised mostly of primary care physicians at hospitals,

medical schools, and medical association meetings throughout the United States.

According to Dr. Winawer, chief of the Gastroenterology Service at Memorial Sloan-Kettering Cancer Center, "Primary care physicians are in an ideal position to reduce the mortality of this disease through early case finding and prompt referral. It is imperative that they have the latest knowledge about colorectal cancer — including the methods available for early detection, diagnosis, management, and follow-up."

For additional information on the Visiting Faculty Program contact Health Learning Systems, Inc., 200 Broadacres Drive, Bloomfield, New Jersey 07003.

Battelle to study long-range market demands in health care industry.

A study to forecast long-range market demands in the international health care industry is being proposed by researchers at Battelle's Columbus Division.

According to George J. Nielson, who will head Battelle's study team, the future health care market is uncertain because of a number of rapidly changing factors, particularly shifting population, government regulations, physicians' practice patterns and advances in medical technology.

"This study," Nielson said, "will help decision-makers understand how these and other environmental factors will influence future demand for health care services. With this information, organizations will be prepared to identify changes in demand and to anticipate threats and opportunities as a result of these changes."

During the study, Battelle experts will project the number of patients requiring medical or surgical care. They also will forecast the demand for health care resources, including diagnostic and therapeutic services, and direct-care units. Experts will compare the projected number of bed days to the available capacity in such units.

In addition, researchers will identify market segments that are likely to evolve because of changes in technology, social or governmental policy and events that may cause these changes.

In conducting the study, Nielson said, Battelle also will examine the factors that affect market demand. These include mortality, fertility, illness occurrence, preventive health intervention programs, federal policy regulating eligibility for care, and developments in resources to care for the sick.

Dementia in elderly may be only a treatable depression.

Six percent of Americans between the ages of 75 and 84 years and 20 percent of those older than 85 years often are institutionalized for mental problems in hospitals for the chronically ill or in nursing homes. However, in some of these patients, dementia — the catch-all phrase for mental conditions — stems from treatable medical problems, not brain damage, and can be reversed through careful diagnosis and treatment, according to Boston physicians writing in a recent issue of the *Journal of the American Medical Association*.

Telling the difference between reversible and irreversible dementia often is difficult, says one of the authors, Thomas D. Sabin, M.D., Director of Neurology at Boston City Hospital. Dementia caused by brain damage can be indistinguishable from the dementia-like symptoms of depression, which will sometimes respond to antidepressant drugs. Also, patients may have treatable disorders occurring in combination with brain damage, further complicating the clinical picture.

The elderly are particularly

susceptible to behavioral alterations caused or aggravated by overmedication, particularly with tranquilizers, according to Dr. Sabin. Contributing medical conditions can include poor diet and dehydration.

"An elderly patient, hospitalized for an acute illness, can become confused and disoriented in reaction to medication and the dramatic change in lifestyle," he explains. "Tranquilizers compound rather than ease dementia-like symptoms. As behavior continues to deteriorate, family and physicians see long-term institutionalization as the only alternative."

"It's a vicious circle for elderly patients labeled as demented," Dr. Sabin warns. Long-term institutionalization, with separation from family, loss of independence and inadequate sensory stimulation, may itself predispose some patients to dementia, he speculates. "Elderly patients institutionalized for longer than six months have little chance of being discharged unless it is for transfer to a hospital for the care of an acute illness."

MISCELLANEA

A new prescription drug for mild to moderate pain and osteoarthritis has been approved by the U.S. Food and Drug Administration (FDA). Called Dolobid (diflunisal, MSD), the drug has been described as a therapeutic gain because it is highly potent, nonnarcotic, and unusually long acting.

The new prescription drug was just approved for acute and chronic cases of mild-to-moderate pain and for osteoarthritis. It has been classified by the government as a 1-B drug (a new chemical entity representing a therapeutic gain). Dolobid has been

shown to be highly effective in the treatment of pain associated with general and orthopedic surgery, oral surgery, episiotomy, and muscular strains and sprains.

"Clinical studies have shown that Dolobid has an unusually long duration of analgesic action, with a plasma half-life of 8 to 12 hours, making it a highly effective twice-a-day analgesic for most patients," said Dr. Marvin E. Jaffe, M.D., vice president for clinical research of the Merck Sharp and Dohme Research Laboratories (MSDRL) who manufacture the drug.



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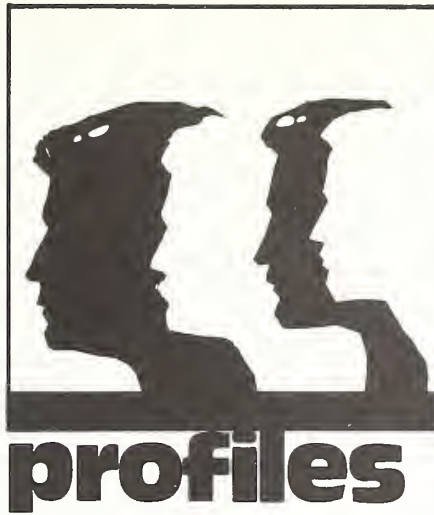
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1. Promoting Health/Preventing Disease: Objectives for the Nation. U.S. Department of Health and Human Services, November 1980.
*An in vitro simulation of gastric ulcer acid level conditions based on standard laboratory methodology. Data on file. Ayerst Laboratories. Acid-neutralizing capacity of RIOPAN and RIOPAN PLUS = 13.5 mEq/5 ml or tablet.

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The Troubleshooter

Whether it's plunging into the water drainage problem of his home community, or concerning himself with the health and welfare of Central Ohio children, Dr. Albert May proves time and time again that he's the man to call when there's a problem . . .

By Carol Wright Mullinax

If you occasionally find yourself knee-deep in other people's problems, Albert May, M.D., can identify with you. When his community of Marion's longstanding water drainage problem left many citizens literally knee-deep in raw sewage, he embarked on a course of action that led him through the White House and eventually resolved the persistent problem. It may sound like an overwhelming task, but people who know Al May weren't surprised. He is a dedicated, hard-working pediatrician whose love of children and zest for life has gotten him involved in a vast array of pursuits.

His campaign to clean up Marion's water problem began innocently enough a few years ago when the local

county sanitarian invited Dr. May to attend a meeting in which Marion's water problem was to be discussed. The community has had water problems for the past forty years. They are the result of Marion's rapid expansion into surrounding farmland which has placed unprecedented demands on the community's drainage system. Outside of the city limits, there were no codes governing the disposal of waste and many people found the raw sewage from area septic tanks bubbling to the surface. The city applied for a grant to study the problem from the Ohio Department of Housing and Urban Development. When the grant was turned down, an irate and aghast local citizen wrote a strongly worded letter to then-

President Carter demanding help. This letter filtered down through the government's bureaucratic maze and resulted in the meeting to which Dr. May was invited. He says, "I decided to go and sit quietly in the back."

It wasn't as if Dr. May didn't already have enough to do. Besides a busy practice as Head of Pediatrics at Smith Clinic in Marion, he was serving as Chairman for Central Ohio International Year of the Child. His success in getting Marion and its surrounding area involved in IYC — a success by the way that he credits to the fact that his community was already organized from his campaign in 1974 to establish the Early Periodic Screening, Diagnosis and Treatment Program — had gotten attention on a



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The Troubleshooter

national level. He had been to the United Nations several times to talk with the IYC group about the accomplishments of Central Ohio IYC. With these added responsibilities, he was barely keeping his head above water.

So when he said he intended to sit quietly back and listen, he meant it. But, characteristically, he found that he couldn't just sit back and watch. Instead, he offered to make the water problem a regional IYC project. The group was so impressed it decided to send Dr. May to Washington to tackle the problem in person.

Feeling just a little like the mouse who's been elected to tie the bell around the cat's neck, May accepted the challenge. But before leaving for Washington, he did some groundwork. It is a character trait which has served him well in all of the projects with which he is involved. First, he armed himself with the facts. He requested a house-to-house study by the Health Department to determine the extent of the health problems stemming from poor drainage. And secondly, he worked behind the scenes to make certain that when he reached Washington he would be talking to the right people. One of the people he contacted was Patricia Harbour, Ph.D., the White House's liaison with all of the country's Federal IYC activities. He had met and talked with her at a previous IYC meeting. She arranged meetings for him with 13 different governmental agencies and bureaus, including the State Department, the Department of Agriculture, Environmental Protection Agency and the Bureau of Land and Water Management.

A few weeks later, documentation in hand, Dr. May made the rounds. At every stop one piece of evidence, a photograph of a two-year-old child playing ankle-deep in raw sewage, grabbed everyone's attention. Dr. May's succinctly worded reply to the question: "What is the child standing in?" provided the impetus for the

\$713,000 grant Marion received from HUD. The resulting project to solve the community's water drainage problem will be completed this year.

Dr. May's success in tackling and solving Marion's water drainage problem has also had results on a national level. One of the dilemmas facing all of the coalitions formed during International Year of the Child was: where do we go from here? Technically, the coalitions were supposed to end in December of 1979. But Dr. May couldn't stand by and let that happen. "At the end of the International Year of the Child do we forget about the kids, do we let local, state and national coalitions die?" he asked. That was one of the reasons he was so eager to have his local IYC group adopt Marion's water drainage problem as a project: it gave the group a purpose which extended beyond the stated IYC deadline. When 1979 ended, at Dr. May's suggestion, instead of fading quietly away, the Central Ohio IYC evolved into Action for Children, Inc., a nonprofit organization dedicated to studying and publicizing the needs of Central Ohio children. The group, which covers Richland, Morrow, Crawford, Wyandotte, Hardin, Marion, Delaware and Union Counties, works to encourage community action involving both governmental and nongovernmental agencies. Dr. May's strategy was so successful in keeping the group viable that it is now being copied by former IYC groups all over the country.

Dr. May's concern for the health and welfare of children has gotten him involved in other groups as well. He serves on the Government Relations Committee of the American Group Practice Association, as Legislative Chairman of the American Academy of Pediatrics Community Health Section, as an advisor to the Ohio Legal Rights Service and as a Board member of the Institute for Child Advocacy. But he still has time in his busy schedule to think about the educational needs of

continued on page 732



Albert May, M.D.

Feeling just a little like the mouse who's been elected to tie the bell around the cat's neck, May accepted the challenge.

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Anthony Ruppensburg, M.D., Columbus, steals a minute from a busy practice to check with a concerned mother.

A Personal Crusade

By Gina DiBlasio Cummins

After 50 years of delivering over 7,000 babies, Anthony Ruppensburg, M.D., a Columbus gynecologist and obstetrician, has become a family tradition. The bouncing baby daughters he delivered two and three decades ago are reappearing at his office all grown up — to have their babies delivered.

"Even at age 75, the challenge of bringing lovely new life into the world safely has not diminished for me," he says, adding, "I still love my work."


In addition to introducing so many infants to life, Dr. Ruppensburg has devoted most of his practice to improving maternal health care and has only recently, after 29 years of service, retired as chairman of the Ohio State Medical Association's (OSMA) Committee on Maternal Health.

His interest in maternal health began while attending Jefferson Medical College in Philadelphia, Pa., during the Depression. Each student

had to deliver six babies in order to graduate but he enjoyed the work so much that he prolonged his stay at the clinic and had 129 deliveries to his credit before he became an intern.

"Although the times were tough, people were very appreciative and gracious and that's when I really learned to love obstetrics." He explains that since many people were out of work, they were unable to pay him while others would repay the best they could — with chickens, rabbits,

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A Personal Crusade

"We hoped that by studying the cause of death of a woman today, we could prevent another woman dying tomorrow . . ."

fresh produce or with whatever they could give. "There were a lot of babies named Anthony or "Tony" in South Philadelphia those years," he smiles.

Dr. Ruppensburg graduated from Jefferson in 1933, but since he was unable to afford a residency, he returned to Ohio where he set up a general practice. His dream was to save until he could one day continue his obstetrical studies.

Unfortunately, his practice and plans to continue his studies were interrupted for 5 1/2 years by World War II. During the war he was commander of a station hospital and base surgeon in the Fiji Islands. He has been honored several times with the Army's Legion of Merit Award for his medical and administrative work with the Ohio National Guard. Looking back at his years of military service, however, Dr. Ruppensburg says that the wartime casualties weren't only on the battlefield. "Leaving my wife and one-year-old son for 5 1/2 years was the hardest thing I have ever had to do."

Following his military service, Dr. Ruppensburg attended Margaret Hague Maternity Hospital in New Jersey City, N.J. to finish his residency and then continued studies in obstetrics and gynecology at Jefferson Medical College. His dream realized, Dr. Ruppensburg returned to Columbus to start his new practice.

Soon after setting up his office, however, Columbus' unusually high maternal death rate was brought to his attention. After investigating the problem with Richard L. Meiling, M.D., a fellow obstetrician and gynecologist, Dr. Ruppensburg assumed the project of studying and reducing the maternal death rate in Ohio — a personal crusade that would continue for the next 30 years.

"We found that in one year, 1935, Columbus recorded 4,812 live births with 59 maternal deaths — a horrible maternal death rate of 12.1 per 1,000 live births." Motivated by this unsettling statistic, Drs. Ruppensburg

and Meiling generated support and financial backing for a continuing study from the Columbus Obstetrics-Gynecological Society.

Real encouragement came in 1954 when the OSMA's House of Delegates formed a committee whose purpose was to study every maternal death in Ohio. Dr. Ruppensburg was named chairman of this new committee, a position he relinquished just this past May. "We hoped that by studying the cause of death of a woman today, we could prevent another woman dying tomorrow from the same cause."

Dr. Ruppensburg notes that his committee initiated and has continued many projects including an educational program for medical professionals and the public on how to improve maternal health care in Ohio. In addition, the establishment of the committee formed the first peer review project in Ohio.

He praises the committee's hard work and enthusiastic efforts in reducing the maternal death rate in Ohio and notes that the statistics produced from their studies speak for themselves. During the first ten-year study — 1955 to 1964 — there were 2,266,744 live births in Ohio and 795 maternal deaths with a ratio of 3.5 deaths per 10,000 live births. However, in the next ten-year study — 1965 to 1974 — there were 1,824,740 live births with 433 maternal deaths for a ratio of 2.37 per 10,000 live births.

When the committee first began its studies, the three most common causes of maternal death were hemorrhaging, infection and toxemia. "These causes are slowly disappearing due, in part, to more women giving birth in hospitals where good medical training exists and because maternal health care in general has greatly improved." He adds that although there are new causes of maternal deaths, advanced research and new treatment will perhaps eradicate these factors as well.

Although Dr. Ruppensburg has retired as chairman of the committee,

he has hardly slowed down. He remains an archivist on the committee and currently is compiling a quarter-century study of maternal deaths in Ohio. He also is teaching obstetrics-gynecologic clinics several days a week at Ohio State University in addition to commanding a crowded office where he continues to educate women on new advances in maternal health care. And, of course, he still delivers babies.

Dr. Ruppensburg's pace may seem hectic, but he finds it very rewarding. "It's especially complimentary to have women I delivered 20 and 30 years ago ask me to deliver their babies. It seems like a natural request since I regard them all as my extended family."

Included in his "family" are the only set of triplets he has ever delivered — the great event occurring 32 years ago on his birthday. "This mother came in with an abdomen as large as an elephant's belly. Using x-ray I could see the three little heads and their delivery was quite a three-ring circus in the operating room. The triplets are all grown up now and doing fine — in fact, I still send them cards on our birthday."

This "keeping in touch" with his patients is very important to Dr. Ruppensburg and perhaps the most gratifying times in his practice are when second and third generation families he has delivered are shopping downtown and decide to stop by his office to visit. "They'll stop in just to say hello and I pass out lollipops and cookies which I keep for these occasions. I guess that's what you call 'living with your practice.' It's a wonderful sensation."

Gina DiBlasio Cummins is Editor of Synergy and a staff writer for the Ohio State Medical Journal.

Because uropathogens on vaginal cells...

New *in vitro* studies indicate specific *E. coli* receptors on the urogenital epithelium may be an important factor in recurrent infection.

Researchers have recently identified a chemical receptor for *E. coli* on the uroepithelial cells of women who are subject to recurrent urinary tract infections.¹

The receptor is a glycosphingolipid known as α -D-Galp (1 \rightarrow 4)- β -D-Galp. This carbohydrate is an antigen found on the red blood cells and the uroepithelial cells of women who have P-positive phenotypes.^{1,2} It is *not* present on the erythrocytes or uroepithelial cells of women who are P-negative. Women who belong to the rare P-negative blood group had a much lower capacity for binding uropathogenic *E. coli* to their urogenital cells *in vitro* and had never experienced recurrent urinary tract infection. The cells from P-positive women, on the other hand, had a very high capacity for binding virulent *E. coli*. These women are generally much more likely to get recurrent infections. The chemical receptor appears to be a major factor responsible for this.¹

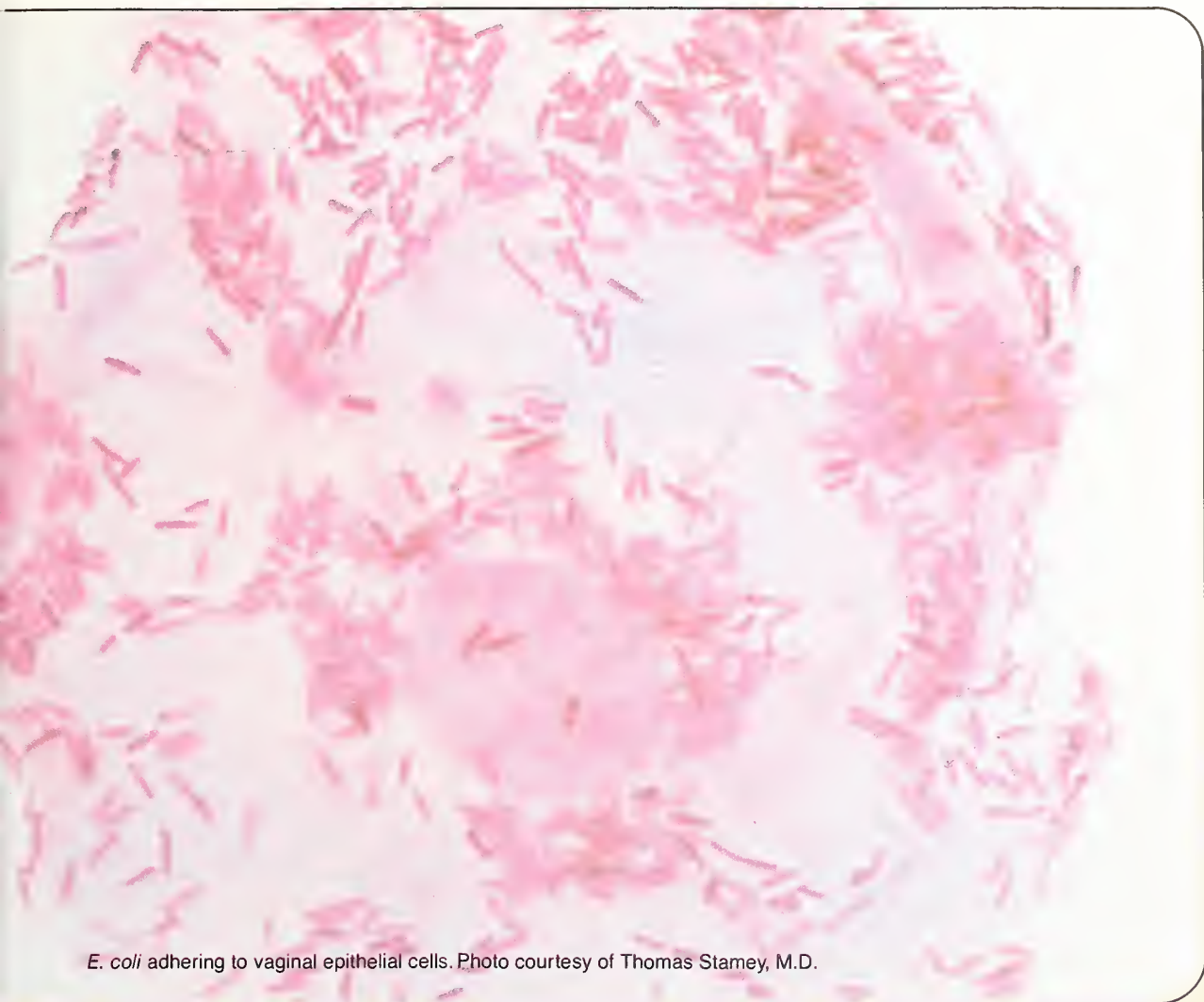
Adherence of *E. coli* to vaginal mucosal cells increases susceptibility to urinary infections.

Another study, comparing women who experienced three or more urinary tract infections per year with healthy controls, found that vaginal cells from the women with recurrent urinary infections had a greater tendency to bind *E. coli in vitro*—even when the cells were cultured while there was no infection. The researchers speculated that deficient host defense mechanisms in vaginal mucosal cells may be responsible for recurrent urinary infections in many women.³ *E. coli* and other uropathogens may colonize the vaginal introitus, adhere to receptors on mucosal cells and then infect the urinary tract.

Get to the source of recurrent urinary tract infection* with

*Due to susceptible organisms such as *E. coli*, *Klebsiella-Enterobacter* and *Proteus* species.

cling to receptors



E. coli adhering to vaginal epithelial cells. Photo courtesy of Thomas Stamey, M.D.

The pharmacologic and pharmacokinetic activities of Bactrim (trimethoprim and sulfamethoxazole/Roche) make it particularly appropriate for the treatment of recurrent urinary infections.* The vast majority of *E. coli* strains and a wide spectrum of other common uropathogens are susceptible to Bactrim *in vitro*.⁴ Bactrim achieves high concentrations in the urine, and the trimethoprim component diffuses into the vaginal area and attacks susceptible uropathogens that cling to mucosal cells.⁵ In the fecal flora, Bactrim suppresses Enterobacteriaceae,⁶ with little resulting emergence of resistant organisms. Bactrim is contraindicated in pregnancy at term, nursing mothers, infants under two months of age and documented megaloblastic anemia due to folate deficiency.

Bactrim DS. Twice a day for 10 to 14 days in recurrent urinary tract infections.*

* Due to susceptible organisms such as *E. coli*, *Klebsiella-Enterobacter* and *Proteus* species.

Bactrim™ DS

(trimethoprim and sulfamethoxazole/Roche)

Economical
and
effective
b.i.d.
therapy.

See next page for references and a summary of product information.

References: 1. Källén G *et al*: *Lancet* 2:604-606, Sep 19, 1981. 2. Lomberg H *et al*: *Lancet* 1:551-552, Mar 7, 1981. 3. Schaeffer AJ *et al*: *N Engl J Med* 304:1062-1066, Apr 30, 1981. 4. BacData Medical Information Systems: *Antibiotic Sensitivity Report*, Winter Series, 1981. 5. Stamey TA, Condly M: *J Infect Dis* 131:261-266, Mar 1975. 6. Rubin RH, Swartz MN: *N Engl J Med* 303:426-431, Aug 21, 1980.

Bactrim^{DS}

(160 mg trimethoprim and 800 mg sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Use: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli*, *Klebsiella-Enterobacter*, *Proteus mirabilis*, *Proteus vulgaris*, *Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibiotic agent rather than the combination. Note: The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections. For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL

PHARYNGITIS. Clinical studies show that patients with group A β -hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hemopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended, therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: General: Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: Double Strength (DS) tablets, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100; Tel-E-Dose[®] packages of 100; Prescription Paks of 20 and 28. Tablets, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose[®] packages of 100; Prescription Paks of 40. Pediatric Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). Suspension, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).



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An Opinion on Emergency Medicine

(continued from page 673)

emergency department or come after considerable deliberation. Their complaint may be "routine" but in a majority of cases the experienced physician can determine quickly the patient's cause for concern. A specialist can do much to soothe the traditionally raw interface between public and hospital that the emergency department has become.

The direction emergency medicine will take is a more complex concern. We went rapidly from "a good idea" to a specialty, and the next few years will be time for consolidation. That is, the literature will be reviewed; accurate textbooks and other reference sources will become available; the residencies will stabilize in numbers and quality; and research topics and techniques will improve. The field will have the same divisions of interests as are found in the traditional specialties. Prehospital care, private practice, group management, education, research, and combined activities with critical care medicine, internal medicine, pediatrics, and others will all develop under the broad title of emergency medicine.

To those quick to offer radical cures and doubtful prognosis for this new field, we can only ask for intelligent temperance. We operate in a fishbowl, forever exposed to the scrutiny of hindsight and easy prey for the "morning after" critique. We have no interest in developing in a vacuum, and need the opinions and perspectives on medical care offered by other services. At the same time, judgment without trial will defeat our mutual goals. We have the talent, insight, and caring to offer a new and viable branch to the whole of medical practice. Emergency medicine should not be debated; it should be welcomed into the medical community as a useful and constructive ally in health care.

Glenn C. Hamilton, M.D., Dayton, is Chairman, Department of Emergency Medicine, Wright State University. Alexander T. Trott, M.D., Cincinnati, is Assistant Professor, Emergency Medicine, University of Cincinnati.



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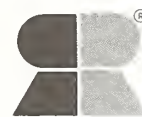
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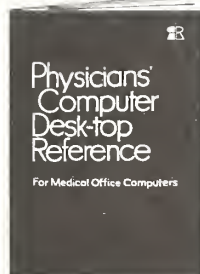
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THE MOST WIDELY PRESCRIBED BETA BLOCKER IN THE WORLD

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BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)
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BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

CONTRAINDICATIONS

1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless it is secondary to a tachyarrhythmia treatable with propranolol, 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE In congestive heart failure, inhibition with beta-blockade carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. In patients already receiving digitalis, propranolol may reduce the positive inotropic action of digitalis and may have an additive depressant effect on AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, in rare instances, cardiac failure has developed during propranolol therapy. At the first sign of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and observed closely a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol should be immediately withdrawn, b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when Inderal is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Give special consideration to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Propranolol should be withdrawn slowly, since abrupt withdrawal may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta-blockade impairs the ability of the heart to respond to reflex stimuli. Except in pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery. In case of emergency surgery, the effects of propranolol can be reversed by administration of beta-receptor agonists such as isoproterenol or levaterenol, but such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), administer with caution, since propranolol may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta-receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA Propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia, especially in patients with labile diabetes. A precipitous elevation of blood pressure may accompany hypoglycemic attacks.

USE IN PREGNANCY Safe use in human pregnancy not established. Embryotoxic effects have been seen in animals at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if propranolol is administered, since it may occasionally produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

Observe laboratory parameters at regular intervals. Use with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura. **Central Nervous System** lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to cataplexy, visual disturbances; hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. **Gastrointestinal** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. **Allergic** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. **Respiratory** bronchospasm. **Hematologic** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. **Miscellaneous** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta-blocker (practolol) have not been conclusively associated with propranolol. **Clinical Laboratory Test Findings** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

HOW SUPPLIED

TABLETS

—Each hexagonal-shaped, orange, scored tablet is embossed with an "I" and imprinted with "INDERAL 10," contains 10 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0421-81) and 1,000 (NDC 0046-0421-91). Also in unit dose package of 100 (NDC 0046-0421-99).

—Each hexagonal-shaped, blue, scored tablet is embossed with an "I" and imprinted with "INDERAL 20," contains 20 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0422-81) and 1,000 (NDC 0046-0422-91). Also in unit dose package of 100 (NDC 0046-0422-99).

—Each hexagonal-shaped, green, scored tablet is embossed with an "I" and imprinted with "INDERAL 40," contains 40 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0424-81) and 1,000 (NDC 0046-0424-91). Also in unit dose package of 100 (NDC 0046-0424-99).

—Each hexagonal-shaped, yellow, scored tablet is embossed with an "I" and imprinted with "INDERAL 80," contains 80 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0428-81) and 1,000 (NDC 0046-0428-91). Also in unit dose package of 100 (NDC 0046-0428-99).

The appearance of these tablets is a trademark of Ayerst Laboratories.
Store at room temperature (approximately 25° C).

INJECTABLE

—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10 (NDC 0046-3265-10).
Store at room temperature (approximately 25° C).

7997/882

Reference: 1 Freis, E. D. Hypertension (Suppl. II) 3:230 (Nov-Dec) 1981

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Taking Charge

If you want to improve the cash flow in your practice, then let the OSMA show you how its newest membership benefit can let you take charge and do just that . . .

By Carol Wright Mullinax

If your practice could profit from improved cash flow and increased working capital, the OSMA has a new member benefit that you may want to consider. Working through the Huntington National Bank, the OSMA is offering a Bank Card Plan which enables your patients to charge their bill to either their VISA or MasterCard. OSMA President C. Douglass Ford, M.D., answers some commonly asked questions about the new plan.

JOURNAL: What prompted the OSMA to offer this plan as a member benefit?

DR. FORD: We are responding to a need our members have expressed for assistance in improving the business aspect of their medical practice. We know that physicians, like everyone else, have been affected by this country's economic condition. Now, more than ever, physicians are plagued by delayed payments,

collection problems and bad debts. The OSMA Bank Card Plan, since it permits patients to put their doctor bill on their bank card, will mean that physicians can be paid promptly for services rendered. In addition, it will help lessen the bookkeeping and paperwork problems that most physicians face. We are confident that this plan will help physicians improve their cash flow.

JOURNAL: How does the new Bank Card Plan actually operate?

DR. FORD: The physician must have a business checking account at one of the Huntington National Banks. Physicians who live in communities without a Huntington branch office still are able to use the Plan as all transactions can be handled easily by mail. A minimum deposit of \$10 is required to open an account. In addition, there is a small fee for the initial check and deposit ticket order.

Once the business details are completed, the physician and patient are ready to benefit by the program. At the end of an office visit, when patients would normally pay or ask to be billed, they could use their MasterCard or VISA. Physicians who do not now have a bank card imprinter may purchase one from the Huntington for \$25 and physicians who already own imprinters will be supplied with an identification plate free of charge.

The physician then deposits the payment either by mail or in person and the account is credited immediately for that transaction. In return for handling the account, once a month the Huntington will deduct 2.75% of the physician's gross monthly bank card sales volume. I want to impress upon members that this percentage — 2.75 — is a special discount rate that the OSMA

"We are responding to a need our members have expressed for assistance in improving the business aspect of their medical practice . . ."



C. Douglass Ford, M.D., Toledo, signs the papers which puts the OSMA's new Bank Card Plan into action.

negotiated with the Huntington. It is much lower than the rate that banks usually charge and that rate is guaranteed through July 31, 1983.

JOURNAL: Will the physician have a record of all the transactions for his bookkeeping purposes?

DR. FORD: Yes. The Huntington will send the physician's office a detailed accounting of their financial transactions. This will include both a monthly checking account statement and a "discount advice" which totals all of the physician's bank card transactions for the month and deducts the operating fee of 2.75%. If a physician needs separate monthly accounting for different partners, the Huntington will set up more than one account.

JOURNAL: Besides the financial benefits, are there any other reasons OSMA members should consider when enrolling in the plan?

DR. FORD: Yes, I think there is one other very important benefit that members should not overlook: the ease and convenience their patients will enjoy by being able to defray their medical bills with their credit card. Should they so desire, patients will be able to extend their payments to the bank over a period of several months

even as they provide their doctor with the opportunity of maintaining his or her cash flow. I am very happy with the Bank Card Plan because of this reason alone. It benefits both the patient and the physician, and it removes third-party payers from that facet of their contractual relationship.

If you have any questions about the new OSMA Bank Card Plan, please contact Jerry J. Campbell at the OSMA office at (614) 228-6971 or call the Huntington Merchant Services at (614) 469-7564.

Carol Wright Mullinax is the Associate Director, Department of Communications.

In Memory of Someone Else

In a recent newsletter, the American Society of Hospital Pharmacists, Bethesda, Maryland, reported the tragic death of Someone Else.

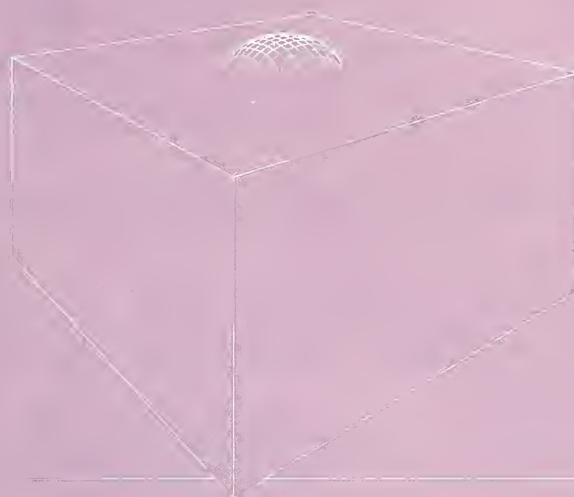
"We were saddened to learn this week of the passing of one of the Society's most valuable members — Someone Else. Someone's passing has created a vacancy that will be difficult to fill. Else worked with the Society for many years and did far more than the normal person's work. Whenever leadership was mentioned, this wonderful person was looked to for inspiration as well as results.

"Whenever there was a job to do or a position to be filled or a meeting to attend, one name was on everyone's lips. 'Let Someone Else do it.'"

Someone is survived by all current society members and will be especially missed by its inactive members. We hope everyone will actively keep Someone Else's memory alive."

Directions/82

OSMA Leadership Conference
November 11-13, 1982



Are you a likely candidate for a malpractice suit? What will be the good financial investments during the next few years? Can government afford to foot the bill for its medical care programs in the coming decade? And how will the changing relationship between the physician and the hospital affect the delivery of health care in the future? Get the answers to these and other crucial questions about the future of health care by attending the 1982 OSMA Leadership Conference November 11-13 in Columbus. Hear from the experts how marketing and competition in health care will affect your practice of medicine. Learn how to better communicate with the media

and the public. Find out how political clout and legislative know-how can improve health care delivery. Faculty includes Walter McClure, President, Center for Policy Studies, Minneapolis; Dennis O'Leary, M.D., Dean for Clinical Affairs, George Washington University Medical Center; Howard Collier, Director, Ohio Office of Budget and Management; James Low, consultant with Low and McManis, Washington, D.C., and many more.

Registration is limited to 200, so register early. Complete the form below and return it to Directions/82 OSMA, 600 S. High St., Columbus Ohio 43215.

The program has applied for Category II CME credit.

CUT HERE

Registration for OSMA 1982 Leadership Conference

Name _____

Address _____

Preconference Seminars: \$ 40

(Select One)

- ☐ Media Training Seminar
- ☐ Competition and Marketing
- ☐ Political Involvement

Breakout Sessions (Select Two)

- ☐ Investing
- ☐ Medicine/Business Coalitions
- ☐ Malpractice
- ☐ Physician/Hospital Relations

Conference Registration: \$150

for non-members

\$125

for members

\$ 60

for spouses, county medical society executives, residents and students

(Includes all meals, seminars, and receptions)

Please make checks payable to the Ohio State Medical Association. Mail check and registration form in the enclosed envelope. Hotel reservation information will accompany your confirmation.



Agency Reference

To find the PICO agent(s) in your area, consult the listing below.

AKRON

Frank B. Hall & Company of Ohio
425 West Market Street
Akron, Ohio
Akron (216) 535-2141
Canton (216) 452-1366
Cleveland (216) 579-9224

ATHENS

Earl E. Mathews, Inc.
8 North Court Street
Athens, Ohio 45701
(614) 593-5573

CINCINNATI

Rudd-Pomeroy Agency
105 West Fourth Street
Cincinnati, Ohio 45202
(513) 721-7766

SP Agency
1811 Losantiville Avenue
Cincinnati, Ohio 45237
(513) 531-8700

Wilder, Siegman & Associates
906 Main Street
Cincinnati, Ohio 45202
(513) 381-3100

Thomas E. Wood, Inc.
1500 Carew Tower
Cincinnati, Ohio 45202
(513) 852-6342

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Chillicothe, Ohio 45601
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Cleveland, Ohio 44115
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Columbus, Ohio 43221
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Frank B. Hall & Company of Ohio
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Columbus, Ohio 43212
(614) 488-1191

Insurance Office of Central Ohio
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Columbus, Ohio 43215
(614) 221-5471

The Johnson Insurance Agency
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Columbus, Ohio 43204
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McCaffrey Insurance Agency
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Columbus, Ohio 43221
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Tice, Inc.
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Columbus, Ohio 43215
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Insurance Agency
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Webb Insurance Agency
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MEDINA

Dennis Insurance Agency
9859 Pawnee Road
West Salem, Ohio 44287
Cuyahoga County: (216) 526-5700
Medina County: (216) 948-2345

Humphrey & Cavagna
Insurance Agency
507 Broad Street
Elyria, Ohio 44035
(216) 322-5477

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Insurance Associates of Middletown
One North Main Street
Middletown, Ohio 45042
(513) 424-2481

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(419) 687-6252

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Sylvania, Ohio 43560
(419) 882-7117
Ohio toll-free—800-472-7549

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Toledo, Ohio 43624
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Toledo, Ohio 43604
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Bacon & Associates Agency
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YOUNGSTOWN

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(Also serving Warren and Ashtabula).

The OSMA's Medical Student Section

(Or What Are We Going To Do With All These Medical Students?)

By Jim Augustine and Frank Papay

It was inevitable. Government and medicine have been waltzing around together for so long, so raucously and so clumsily that echoes of their footsteps finally have been heard in the hallowed, ivy-clad halls of medical schools around the country. Suddenly, medical students have come to realize that the practice of medicine is no longer simply a matter of taking their Oath of Hippocrates to the outside world. Indeed, the outside world has become so complex that, if Hippocrates were in practice today, a whole new Oath might very well erupt.

Is it any wonder then, that organized medicine is being met with increasing interest in today's medical schools?

It's a phenomenon that the Ohio State Medical Association (OSMA)

decided to pursue. Late in 1980, the OSMA's Committee on Membership appointed a group of medical students to monitor this increasing interest in organized medicine at their own schools — and to propose, as well, a mechanism by which medical students might become more formally affiliated with the state medical society.

The members of the study group selected for this task were, themselves, avid supporters of student involvement, and each had been active, at one time or another, in the American Medical Association's student section.

So it was hardly surprising that the six students (representing each of Ohio's six medical schools) put together a draft that was enthusiastic in its recommendations for a student section at the state level.

"An important link is missing in student involvement in organized medicine," their proposal began. "The existence of an autonomous Medical Student Section within the OSMA would provide a mechanism for students to discuss and resolve issues that affect their lives and careers."

They envisioned such a section working on projects which uniquely affect and interest medical students — projects such as:

- Developing a service which matches communities in need of physicians with medical students interested in practicing in small, rural communities.
- Providing information to students who wish to expand their knowledge through clerkships and residencies.
- Standardizing information regarding alternative sources of funds

The OSMA's Medical Student Section

available to students for their medical education.

Such projects would lure other students into the association, and ultimately benefit the OSMA.

"Student membership has the potential of adding 3,200 new members to the OSMA," their proposal read, which would, they pointed out, not only provide new strength to the Association — both now and in years to come — but also provide a greater representation as well.

The Committee on Membership, as well as the OSMA Council, concurred and the Student Section became official at the 1981 Annual Meeting.

"The existence of an autonomous Medical Student Section within the OSMA would provide a mechanism for students to discuss and resolve issues that affect their lives and careers."

Bylaws for the Section were drawn up by the six members of the original study group, to include the following objectives: To encourage and support active participation of medical students in the OSMA; to serve as a mechanism for asserting student opinion and ideals regarding organized medicine, and to support the purposes of the OSMA.

Membership is made available to all medical students in good standing at any of Ohio's six medical schools. Each school's members compose a local chapter, with each chapter selecting one representative per 100 members, to serve as a representative at the special Section Assembly, which

meets once a year. A Governing Council, comprised of a President, Vice-President, Secretary, Immediate Past President and the six delegates, presides during interim times.

Each medical school also assumes responsibility for electing their own representative to serve in the OSMA's House of Delegates, which convenes annually. Although student members are not counted at the district level, they do form a separate district within the House.

As a final order of business, the original study group outlined some areas in which the Student Section could function — within the objectives established by its bylaws. They are:

- Academics. The Section could help its members increase both their clinical and scientific knowledge by compiling a list of physicians, willing to offer summer preceptorships for students between their first and second year of medical school. The Section might also be able to function as a "Clearinghouse" for information

regarding third- and fourth-year electives in Ohio.

- Community service. Members of the Student Section could initiate public service projects, and participate in those already established by the OSMA. The members also could serve as public speakers at civic- or school-sponsored, career-oriented programs.

- Services to students. Common needs of students could be explored by the Section, and possibly met. Many students, for example, have expressed interest in obtaining health, life, and liability insurance programs. Cooperative purchasing of widely used textbooks and instruments is another possibility.

- Financial aid. The Student Section is examining the financial aid situation in Ohio, and will make recommendations to the OSMA on what role the Association might play in addressing this crisis. They also are investigating the possibility of initiating a physician loan fund for state medical students.



The OSMA's Medical Student Section held its first Annual Meeting early this year.



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is a side effect
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Dental pain and episiotomy pain are predictable, reproducible "standards" that make possible objective comparisons of effectiveness of different analgesic agents.

- Measured against 15, 30 and 60 mg doses of codeine phosphate in a double-blind study of 287 patients, 400-mg doses of ibuprofen proved "significantly better than codeine on almost all pain intensity, degree of relief and duration of analgesia parameters."²
- Measured against a propoxyphene-acetaminophen combination for pain relief after 3rd molar extractions, ibuprofen proved equally effective and caused fewer side effects. Ibuprofen was associated with faster recovery, evidenced by more rapid reduction of trismus and return to normal function.³
- Measured against post-episiotomy pain in 30 patients, "ibuprofen was effective in treating the swelling as well as pain...during the first and worst days. Therefore, it is not only the analgesic but also the anti-inflammatory effect of ibuprofen that are the beneficial factors..."⁴



Measure RUFEN® (ibuprofen) against any mild to moderate pain

RUFEN	Acetaminophen + codeine combinations
• single-entity, peripheral-acting analgesia	• combined drugs act partly through central opioid pathways
• powerful treatment of both pain and inflammation	• virtually no treatment of the inflammatory component
• better tolerated than aspirin	• combined side effects of two drugs — warning required about driving or operating machinery; possible respiratory depression with alcohol, tranquilizers, other common medications
• no narcotic risk, red tape, records	• narcotic precautions required
• matchless economy in a modern NSAID	

References:

1. Hart FD, Huskisson EC, Ansell BM in Hart FD (editor): Drug Treatment of the Rheumatic Diseases, 2nd Ed. Adis Press, Balgowlah, Australia, 1982, p. 30.
2. Rondeau PL, Yeung E, Nelson P: Canad Dent Assoc J 46:433-439, 1980.
3. Selwyn P and Giles AD: Br Jrl of Clin Practice, Supplement 6, Safe and effective analgesia following dental surgery: A comparison of brufen and distalgic. Pg 87-90, 1980.
4. Taina E: Curr Med Res Opin, 7:423-428, 1981.



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And Rufen® Measures Up Best

RUFEN® (ibuprofen) Tablets

INDICATIONS AND USAGE: Treatment of signs and symptoms of rheumatoid arthritis and osteoarthritis during acute flares and in the long-term management of these diseases. Safety and effectiveness have not been established for Functional Class IV rheumatoid arthritis.

Relief of mild to moderate pain. Treatment of primary dysmenorrhea.

CONTRAINDICATIONS: Patients hypersensitive to ibuprofen, or with the syndrome of nasal polyps, angio-edema and bronchospastic reactivity to aspirin or other nonsteroidal anti-inflammatory drugs (see WARNINGS).

WARNINGS: Anaphylactoid reactions have occurred in patients hypersensitive to aspirin (see CONTRAINDICATIONS). Peptic ulceration and gastrointestinal bleeding, sometimes severe, have been reported. Peptic ulceration, perforation, or gastrointestinal bleeding can end fatally, however, an association has not been established. Rufen should be given under close supervision to patients with a history of upper gastrointestinal tract disease, and only after consulting the ADVERSE REACTIONS.

In patients with active peptic ulcer and active rheumatoid arthritis, nonulcerogenic drugs, such as gold, should be attempted. If Rufen must be given, the patient should be under close supervision for signs of ulcer perforation or gastrointestinal bleeding.

PRECAUTIONS: Blurred and/or diminished vision, scotomata, and/or changes in color vision have been reported. If developed, discontinue Rufen and administer an ophthalmologic examination.

Fluid retention and edema have been associated with Rufen; caution should be used in patients with a history of cardiac decompensation.

Rufen can inhibit platelet aggregation and prolong bleeding time. Use with caution in patients with intrinsic coagulation defects and those taking anticoagulants.

Patients should report signs or symptoms of gastrointestinal ulceration or bleeding, blurred vision or other eye symptoms, skin rash, weight gain or edema.

To avoid exacerbation of disease or adrenal insufficiency, patients on prolonged corticosteroid therapy, this therapy should be tapered slowly when adding Rufen.

DRUG INTERACTION: Coumarin-type anticoagulants. The physician should be cautious when administering Rufen to patients on anticoagulants.

Aspirin: Concomitant use may decrease Rufen blood levels.

PREGNANCY AND NURSING MOTHERS: Rufen should not be taken during pregnancy nor by nursing mothers.

ADVERSE REACTIONS: Incidence greater than 1%. **Gastrointestinal:** The most frequent adverse reaction is gastrointestinal (4 to 16%). Includes nausea*, epigastric pain*, heartburn*, diarrhea, abdominal distress, nausea and vomiting, indigestion, constipation, abdominal cramps or pain, fullness of GI tract (bloating and flatulence). **Central Nervous System:** dizziness*, headache, nervousness. **Dermatologic:** rash* (including maculopapular type), pruritus. **Special Senses:** tinnitus. **Metabolic:** decreased appetite, edema, fluid retention. Fluid retention generally responds promptly to drug discontinuation (see PRECAUTIONS). *Incidence 3% to 9%.

Incidence less than 1 in 100. Gastrointestinal: gastric or duodenal ulcer with bleeding and/or perforation, hemorrhage, melena. **Central Nervous System:** depression, insomnia, confusion, emotional lability, somnolence, aseptic meningitis with fever and coma. **Dermatologic:** vesiculobullous eruptions, urticaria, erythema multiforme, Stevens-Johnson syndrome and alopecia. **Special Senses:** hearing loss, amblyopia (blurred and/or diminished vision, scotomata and/or changes in color vision) (see PRECAUTIONS). **Hematologic:** neutropenia, agranulocytosis, aplastic anemia, hemolytic anemia (sometimes Coombs' positive), thrombocytopenia with or without purpura eosinophilia, decreases in hemoglobin and hematocrit. **Cardiovascular:** congestive heart failure in patients with marginal cardiac function, elevated blood pressure. **Allergic:** syndrome of abdominal pain, fever, chills, nausea and vomiting, anaphylaxis, bronchospasms (see CONTRAINDICATIONS). **Renal:** acute renal failure in patients with preexisting significantly impaired renal function, decreased creatinine clearance, polyuria, azotemia, cystitis, hematuria. **Miscellaneous:** dry eyes and mouth, gingival ulcers, rhinitis.

Causal relationship unknown. Gastrointestinal: pancreatitis. **Central Nervous System:** paresthesias, hallucinations, dream abnormalities, pseudotumor cerebri. **Dermatologic:** toxic epidermal necrolysis, photoallergic skin reactions. **Special Senses:** conjunctivitis, diplopia, optic neuritis. **Hematologic:** bleeding episodes. **Allergic:** serum sickness, lupus erythematosus syndrome, Henoch-Schönlein vasculitis. **Endocrine:** gynecomastia, hypoglycemia. **Cardiovascular:** arrhythmias (sinus tachycardia, bradycardia, and palpitations). **Renal:** renal papillary necrosis.

OVERDOSAGE: Acute overdosage, the stomach should be emptied. Rufen is acidic and excreted in the urine, alkaline diuresis may benefit.

DOSAGE AND ADMINISTRATION: Rheumatoid arthritis and osteoarthritis, including flareups of chronic disease: Suggested dosage 400 mg t.i.d. or q.i.d.

Dysmenorrhea: 400 mg every 4 hours as necessary.

Mild to moderate pain: 400 mg every 4 to 6 hours as necessary for the relief of pain. Do not exceed 2,400 mg per day.

CAUTION: Federal law prohibits dispensing without prescription.

The OSMA's Medical Student Section

- Information exchange. The Section should encourage students to exchange ideas about school programs and practices . . . with the goal of improving education for all.

- Career planning. The Section should gather and make available to students, information about Ohio residency programs and career opportunities. It also may assist in matching interested medical students with Ohio communities seeking future practitioners.

- Extracurricular activities. The Section may wish to conduct social activities, retreats, or seminars for members and physicians.

- Political action. The Section should serve as a forum for discussion of current medical issues.

The OSMA Medical Student Liaison Committee met with the student

group in January 1982, and made three recommendations, all approved by Council:

1. An ad hoc committee, composed predominantly of students, should be appointed to study the Ohio financial aid situation and make suggestions to Council for possible actions. (This function now has been assumed by members of the Medical Student Section Governing Council.)

2. The OSMA should compile a list of physicians willing to offer summer preceptorships for students between their first and second year of medical school.

3. Council should instruct OSMA staff to contact PICO to determine if an appropriate product exists for medical student liability, and if no product exists, to determine whether it is practical to develop a suitable one.

(PICO already has made available health and life insurance programs for students.)

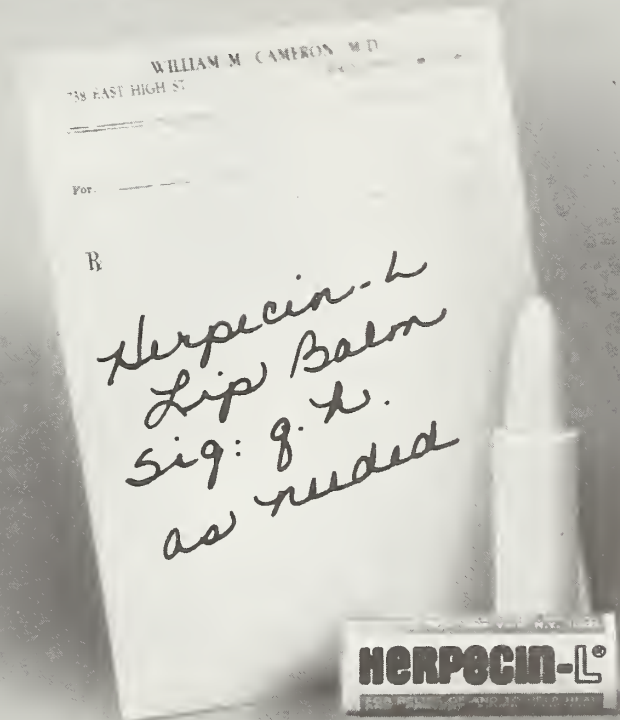
The Medical Student Section will grow only through the efforts of Ohio's medical students and physicians. Your comments and suggestions are greatly needed, and can be directed to:

Medical Student Section
Ohio State Medical Association
600 South High Street
Columbus, Ohio 43215

Jim Augustine is in his fourth year of medicine at Wright State University and is serving as "honorary" past president of OSMA's Medical Student Section.

Frank Papay is in his fourth year at Northeastern Ohio University College of Medicine, and is currently President of OSMA's Medical Student Section.

Dx: recurrent herpes labialis



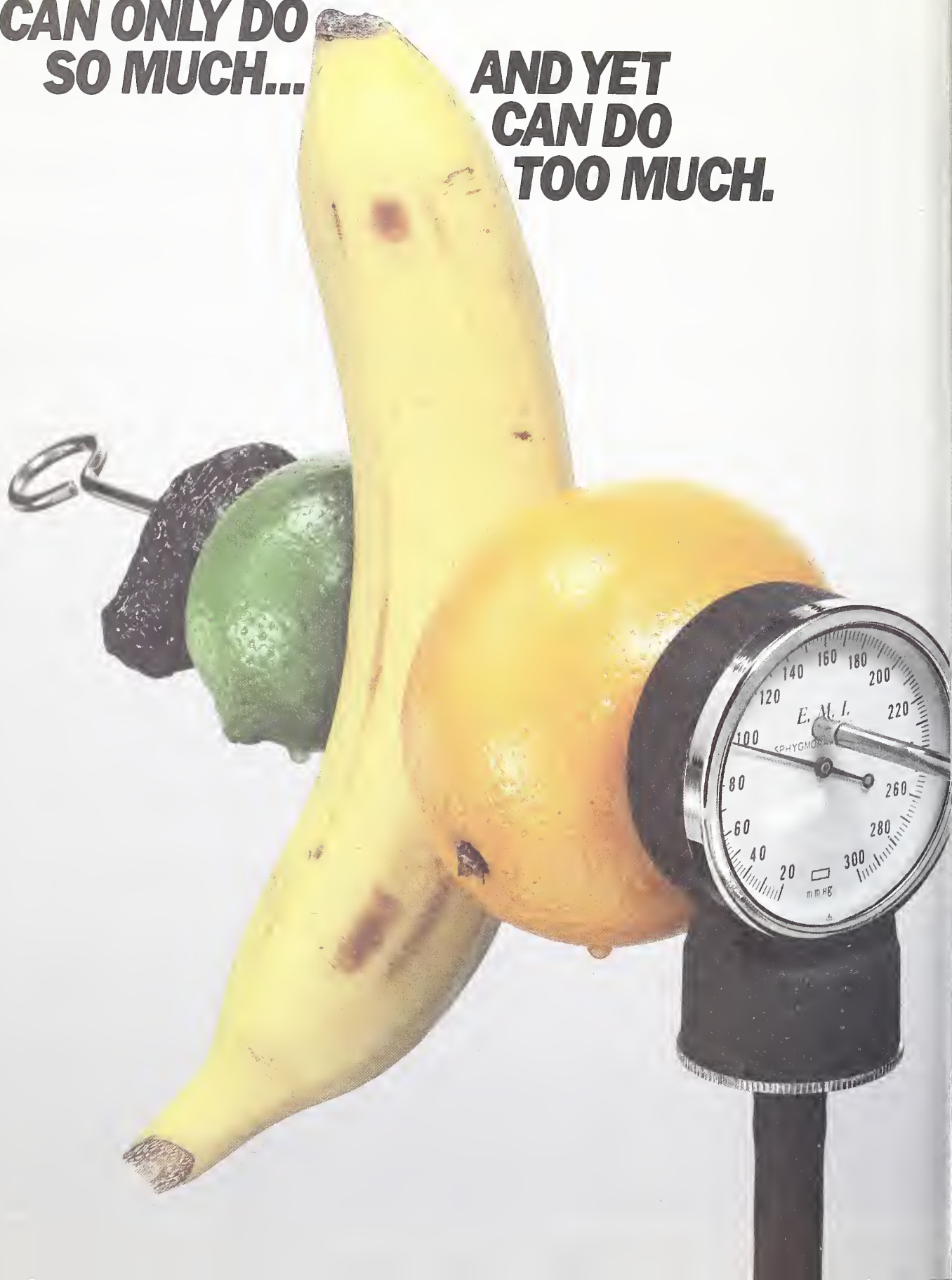
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In Ohio, "Herpecin-L" Lip Balm is available at all Gray and Cunningham Drug Stores and other select pharmacies.

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Many times, a diuretic alone can't keep hypertension in check. *INDERIDE*, however, can pick up where thiazide therapy leaves off.

The combination of propranolol HCl, the world's most trusted beta blocker, and hydrochlorothiazide, the standard among diuretics, enables *INDERIDE* to exert an additive antihypertensive effect.^{1,2} In fact, a propranolol/hydrochlorothiazide regimen maintained blood pressure below 90 mm Hg in 81.8% to 86.4% of patients followed for 6 to 18 months of therapy.⁷

Low thiazide dosage means reduced risk of hypokalemia.

When thiazides are prescribed in doses greater than 50 mg/day, the potential for hypokalemia increases substantially. What's more, the greater the fall in serum K⁺, the greater the risk of hypokalemia-induced PVCs.^{3,4}

With *INDERIDE*, the additive hypotensive effect of propranolol HCl allows the effective dose of hydrochlorothiazide to be kept low (25 mg b.i.d.). And by lowering the daily dose of diuretic, *INDERIDE* also lowers the potential for diuretic-induced side effects. Potassium problems are less likely to occur—yet blood pressure can be controlled consistently.



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Each tablet contains *INDERAL[®]* (propranolol HCl) 40 mg or 80 mg, and hydrochlorothiazide 25 mg | **B.I.D. 40/25
80/25**

When you know you need more than a thiazide.

Please see Brief Summary of Prescribing Information on following page.

INDERIDE[®]

Each tablet contains **INDERAL**
(propranolol HCl) 40 mg or 80 mg,
and hydrochlorothiazide 25 mg

B.I.D. 40/25 80/25



BRIEF SUMMARY

(FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR.)

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No. 484—Each IINDERIDE [®] 40/25 tablet contains:	
Propranolol hydrochloride (INDERAL [®])	40 mg
Hydrochlorothiazide	25 mg
No. 488—Each IINDERIDE [®] 80/25 tablet contains:	
Propranolol hydrochloride (INDERAL [®])	80 mg
Hydrochlorothiazide	25 mg

WARNING: This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

INDICATION: IINDERIDE is indicated in the management of hypertension (See boxed warning.)

CONTRAINDICATIONS: Propranolol hydrochloride (INDERAL[®]): Propranolol hydrochloride is contraindicated in: 1) bronchial asthma; 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block; 4) cardiogenic shock; 5) right ventricular failure secondary to pulmonary hypertension; 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS: Propranolol hydrochloride (INDERAL[®]): **CARDIAC FAILURE:** Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely. a) If cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn. b) If tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

USE IN PREGNANCY: Propranolol hydrochloride (INDERAL[®]): The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in

animal studies at doses about 10 times the maximum recommended human dose.

Hydrochlorothiazide: Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers: Thiazides appear in breast milk. If the use of the drug is deemed essential, the patient should stop nursing.

PRECAUTIONS: Propranolol hydrochloride (INDERAL[®]): Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Warning signs, irrespective of cause are: dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements such as foods with a high potassium content.

Any chloride deficit is generally mild, and usually does not require specific treatment except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum FPI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

ADVERSE REACTIONS: Propranolol hydrochloride (INDERAL[®]): Cardiovascular: bradycardia, congestive heart failure; intensification of AV block; hypotension; paresthesia of hands; arterial insufficiency usually of the Raynaud type; thrombocytopenic purpura.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances; hallucinations; an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Miscellaneous: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

Hydrochlorothiazide: **Gastrointestinal:** anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

Central Nervous System: dizziness, vertigo, paresthesias, headache, xanthopsia.

Hematologic: leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular: orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: purpura, photosensitivity, rash, urticaria, necrotizing angitis (vasculitis, cutaneous vasculitis), fever, respiratory distress including pneumonitis, anaphylactic reactions.

Other: hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

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Secretary-Treasurer, 2403 Central
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October

TREATMENT OF POST-VIETNAM STRESS SYNDROME: October 18-20; Kings Island Inn; sponsor: Human Resource Initiatives, Dayton; cosponsor: Ohio State Medical Association; 19 credit hours; fee: \$225 or \$75 per day; contact: Diane Henry, Human Resources Initiatives, 1040 Smithville Road, Dayton 45403, phone: 513/223-0012.

19TH ANNUAL DIABETES SYMPOSIUM: October 27-28; Fawcett Center for Tomorrow, 2400 Olentangy River Road, Columbus; sponsor: Central Ohio Diabetes Association; cosponsor: Mt. Carmel Medical Center, Columbus; 6 credit hours; fee: \$60; contact: Central Ohio Diabetes Association, 1803 W. Fifth Avenue, Columbus 43212, phone: 614/486-7124.

November

ALLERGY UPDATE — 1982: November 3-4; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$150; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5678.

CINCINNATI CANCER CONFERENCE: BREAST CANCER: November 5-6; The Westin Hotel, Cincinnati; sponsor: Bethesda Hospital & Deaconess Association; cosponsor: American Cancer Society, Hamilton County Unit; 11 1/4 credit hours; fee: \$145, \$72.50 for physicians-in-training; contact: Thomas J. O'Connor, Bethesda Hospital, 619 Oak Street, Cincinnati 45206, phone: 513/559-6337-6339.

DEALING WITH THE LEGAL SYSTEM: PRACTICAL GUIDANCE FOR PHYSICIANS: November 10; Sheraton Dayton Downtown; sponsor: Wright State University School of Medicine; 7 credit hours; fee: \$90, \$70 Wright State faculty; contact: Mary B. Fisher, WSUSOM, Dept. of PMCE, Box 927, Dayton 45401, phone: 513/372-7140.

THE ELDERLY PATIENT AND THE HOSPITAL EXPERIENCE: November 13; The Terrace Hilton Hotel, Cincinnati; sponsor: Bethesda Hospital & Deaconess Association; 6 credit hours; fee: \$75; contact: Thomas J. O'Connor, Bethesda Hospital, 619 Oak Street, Cincinnati 45206, phone: 513/559-6337-6339.

GASTROENTEROLOGY UPDATE — 1982: November 17-18; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; sponsor: Cleveland Clinic Educational Foundation, 12 credit hours; fee: \$150, \$75 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5678.

ADVANCES IN COLON AND RECTAL SURGERY: November 19-20; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland; sponsor: Cleveland Clinic Educational Foundation; 9 credit hours; fee: \$150, \$75 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5678.

CANCER UPDATE: November 21; Hyatt Regency Columbus; sponsor: American Cancer Society, Ohio Division; cosponsor: Ohio State University Comprehensive Cancer Center; 5.5 credit hours; no fee; contact: Frances Helmick, R.N., American Cancer Society, 1375 Euclid Avenue, Room No. 312, Cleveland 44115, phone: 216/771-6700.

December

OBSTETRICS AND GYNECOLOGY SEMINAR: December 1; Holiday Inn, I-76 and Rt. 43, Kent; sponsor: Aultman Hospital, Canton; 6 credit hours; fee: \$40, \$30 for physicians-in-training; contact: Alvin Langer, M.D., 2600 Sixth Street, S.W. Canton 44710, phone: 216/438-6214.

PERSPECTIVES IN OPHTHALMOLOGY: December 2-3; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland 44106; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$190, \$95 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: 216/444-5678.

SHORT COURSES IN PEDIATRICS: Mondays and Fridays throughout year; St. Luke's Hospital, Cleveland; sponsor: St. Luke's Hospital; 1 credit hour each; contact: Robert O. Walton, M.D., St. Luke's Hospital, 11311 Shaker Blvd., Cleveland 44104, phone: 216/368-7170.

Obituaries



LEONARD A. BLUM,
M.D., Pompano Beach, Florida; St.
Louis University School of Medicine,
St. Louis, 1927; age 78; died July 22,
1982; member OSMA and AMA.

PATRICK F. BRIOLA, M.D.,
Cleveland; Case Western Reserve
University School of Medicine, 1932;
age 74; died July 27, 1982; member
OSMA and AMA.

NANCY GREENLEES, M.D.,
Akron; Northeastern Ohio University
College of Medicine, Kent, 1981; age
25; died June 29, 1982; member OSMA
and AMA.

ARNOLD L. HELLER, M.D.,
Cleveland; Case Western Reserve
University School of Medicine, 1944;
age 62; died August 10, 1982; member
OSMA and AMA.

JOHN H. HUNT, M.D., Cincinnati;
University of Cincinnati College of
Medicine, 1928; age 79; died July 10,
1982; member OSMA and AMA.

ROBERT E. LOGSDON, M.D.,
Marion; University of Illinois College
of Medicine, 1938; age 71; died July 3,
1982; member OSMA and AMA.

MARTIN SONDHEIMER, M.D.,
Lima; University of Munich, Germany,
1923; age 86; died August 5, 1982;
member OSMA and AMA.

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INDICATIONS AND USAGE: These preparations are indicated for the treatment of infections caused by susceptible strains of designated microorganisms as follows: Respiratory Tract Infections (e.g., tonsillitis, pharyngitis, and lobar pneumonia) due to *S. pneumoniae* (formerly *D. pneumoniae*) and group A beta-hemolytic streptococci [penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever; Velosef (Cephadrine, Squibb) is generally effective in the eradication of streptococci from the nasopharynx; substantial data establishing the efficacy of Velosef in the subsequent prevention of rheumatic fever are not available at present]; Otitis Media due to group A beta-hemolytic streptococci, *H. influenzae*, staphylococci, and

S. pneumoniae; Skin and Skin Structures Infections due to staphylococci and beta-hemolytic streptococci; Urinary Tract Infections, including prostatitis, due to *E. coli*, *P. mirabilis*, *Klebsiella* species, and enterococci (*S. faecalis*).

Note: Culture and susceptibility tests should be initiated prior to and during therapy.

CONTRAINDICATIONS: In patients with known hypersensitivity to the cephalosporin group of antibiotics.

WARNINGS: Use cephalosporin derivatives with great caution in penicillin-sensitive patients since there is clinical and laboratory evidence of partial cross-allergenicity of the two groups of antibiotics; there are instances of reactions to both drug classes (including anaphylaxis after parenteral use). In persons who have demonstrated some form of allergy, particularly to drugs, use antibiotics, including cephadrine, cautiously and only when absolutely necessary.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use. Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro*. Mild cases of colitis may respond to drug discontinuance alone. Manage moderate to severe cases with fluid, electrolyte and protein supplementation as indicated. Oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis.

produced by *C. difficile* when the colitis is severe or is not relieved by drug discontinuance; consider other causes of colitis.

PRECAUTIONS: General: Follow patients carefully to detect any side effects or unusual manifestations of drug idiosyncrasy. If a hypersensitivity reaction occurs, discontinue the drug and treat the patient with the usual agents, e.g., pressor amines, antihistamines, or corticosteroids. Administer cephradine with caution in the presence of markedly impaired renal function. In patients with known or suspected renal impairment, make careful clinical observation and appropriate laboratory studies prior to and during therapy as cephradine accumulates in the serum and tissues. See package insert for information on treatment of patients with impaired renal function. Prescribe cephradine with caution in individuals with a history of gastrointestinal disease, particularly colitis. Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. Take appropriate measures should superinfection occur during therapy. Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

Information for Patients: Caution diabetic patients that false results may occur with urine glucose tests (see PRECAUTIONS, Drug/Laboratory Test Interactions). Advise the patient to comply with the full course of therapy even if he begins to feel better and to take a missed dose as soon as possible. Tell the patient he may take this medication with food or milk since G.I. upset may be a factor in compliance with the dosage regimen. The patient should report current use of any medicines and should be cautioned not to take other medications unless the physician knows and approves of their use (see PRECAUTIONS, Drug Interactions).

Laboratory Tests: In patients with known or suspected renal impairment, it is advisable to monitor renal function.

Drug Interactions: When administered concurrently, the following drugs may interact with cephalosporins:

Other antibacterial agents — Bacteriostats may interfere with the bactericidal action of cephalosporins in acute infection; other agents, e.g., aminoglycosides, colistin, polymyxins, vancomycin, may increase the possibility of nephrotoxicity.

Diuretics (potent "loop diuretics," e.g., furosemide and ethacrynic acid) — Enhanced possibility for renal toxicity.

Probenecid — Increased and prolonged blood levels of cephalosporins, resulting in increased risk of nephrotoxicity.

Drug/Laboratory Test Interactions: After treatment with cephradine, a false-positive reaction for glucose in the urine may occur with Benedict's solution, Fehling's solution, or with Clinistix® tablets, but not with enzyme-based tests such as Clinistix® and Tes-Tape®. False-positive Coombs test results may occur in newborns whose mothers received a cephalosporin prior to delivery. Cephalosporins have been reported to cause false-positive reactions in tests for urinary proteins which use sulfosalicylic acid, false elevations of urinary 17-ketosteroid values, and prolonged prothrombin times.

Carcinogenesis, Mutagenesis: Long-term studies in animals have not been performed to evaluate carcinogenic potential or mutagenesis.

Pregnancy: Teratogenic Effects/Impairment of Fertility — Category B: Reproduction studies have been performed in mice and rats at doses up to 4 times the maximum indicated human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cephradine. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

Nursing Mothers: Since cephradine is excreted in breast milk during lactation, exercise caution when administering cephradine to a nursing woman.

Pediatric Use: Adequate information is unavailable on the efficacy of b.i.d. regimens in children under nine months of age.

ADVERSE REACTIONS: Untoward reactions are limited essentially to G.I. disturbances and, on occasion, to hypersensitivity phenomena. The latter are more likely to occur in persons who have previously demonstrated hypersensitivity and those with a history of allergy, asthma, hay fever, or urticaria.

(continued on next page)

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(continued)

The following adverse reactions have been reported following use of cephadrine: G.I. — Symptoms of pseudo-membranous colitis can appear during antibiotic therapy; nausea and vomiting have been reported rarely. Skin and Hypersensitivity Reactions — mild urticaria or skin rash, pruritus, joint pains. Blood — mild transient eosinophilia, leukopenia and neutropenia. Liver — transient mild rise of SGOT, SGPT, and total bilirubin with no evidence of hepatocellular damage. Renal — transitory rises in BUN have been observed in some patients treated with cephalosporins; their frequency increases in patients over 50 years old. In adults for whom serum creatinine determinations were performed, the rise in BUN was not accompanied by a rise in serum creatinine. Others — dizziness, tightness in the chest, and candidal vaginitis.

DOSAGE: Adults — For respiratory tract infections (other than lobar pneumonia) and skin and skin structures infections: 250 mg q. 6 h or 500 mg q. 12 h. For lobar pneumonia: 500 mg q. 6 h or 1 g q. 12 h. For uncomplicated urinary tract infections: 500 mg q. 12 h; for more serious UTI, including prostatitis, 500 mg q. 6 h or 1 g q. 12 h. Severe or chronic infections may require larger doses (up to 1 g q. 6 h.).

Children over 9 months of age — 25 to 50 mg/kg/day in equally divided doses q. 6 or 12 h. For otitis media due to *H. influenzae*: 75 to 100 mg/kg/day in equally divided doses q. 6 or 12 h but not to exceed 4 g/day. Dosage for children should not exceed dosage recommended for adults. There are no adequate data available on efficacy of b.i.d. regimens in children under 9 months of age.

For full prescribing information, consult package insert.

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CLINICAL NOTES

Edited by Karen S. Edwards

Occult CO Poisoning

Occult CO poisoning is a form of severe accidental CO poisoning in which CO exposure is initially unknown to the patient, and usually the physician. In recent cases, two exposures were caused by the use of kerosene space heaters, and two were related to defective home heating with inadequate ventilation.

Concern about fuel costs and availability has led some consumers to reduce ventilation in their homes and offices in winter months, and to purchase portable kerosene space heaters. As a result, there has been an increase in occult CO poisoning.

Diagnosis can be made only when clinical suspicion is high. During winter months, patients initially seen with severe headache, nausea, vomiting, decreased cognitive function, or new onset angina pectoris should be questioned concerning similarly affected cohabitants, faulty ventilation, defective heating or the use of space heaters.

The recognition of the disorder and the removal of the patient from the contaminated environments are the critical treatments to avoid serious morbidity and potential mortality.

Archives of Internal Medicine
July, 1982. Volume 142, No. 7
pgs. 1270-1271

PCP Abuse

Phencyclidine (PCP) abuse is a nationwide problem, and death is not an uncommon result. These deaths are rarely attributed to primary drug effects, but are usually secondary to the drug's "behavioral toxicity." Its victims usually die as a result of trauma or drowning. Phencyclidine may be smoked inadvertently by persons who think it is marijuana.

The patient studied in this article suffered a spontaneous intracranial hemorrhage after smoking PCP. Autopsy demonstrated no vascular anomaly that would predispose the patient to suffer such an event. Extensive toxicological testing disclosed only PCP, nicotine and benzodiazepines, and there was no history of significant trauma. A primary effect of PCP must therefore be postulated as the cause of this patient's death.

The recognition of intracranial hemorrhage associated with phencyclidine abuse has definite clinical relevance. It is not uncommon for patients with PCP intoxication to be brought to the hospital in a comatose state. This coma is usually self-limited and needs little treatment other than general supportive

measures. Intracranial hemorrhage, however, can cause intracranial hypertension, which may respond to specific medical or surgical intervention.

Although intracranial hemorrhage is a rare complication of PCP abuse, it is both potentially lethal and potentially treatable; hence its recognition is important. Computed tomographic scanning should be considered in the patient whose comatose state is presumed to be caused by the CNS-depressant effects of PCP.

JAMA

August, 1982. Vol. 248, No. 5
pgs. 585-586

Exertional headaches

Some experts estimate that up to four percent of the adult population engages in weight lifting occasionally, and up to 46 percent of the adult population has a regular fitness program. In this particular case report, a 30-year old man had recently begun a personal fitness program, including a form of circuit training on weight-lifting machines.

Several days prior to admission, he experienced the sudden onset of an explosive, diffuse headache while

Continued on page 721



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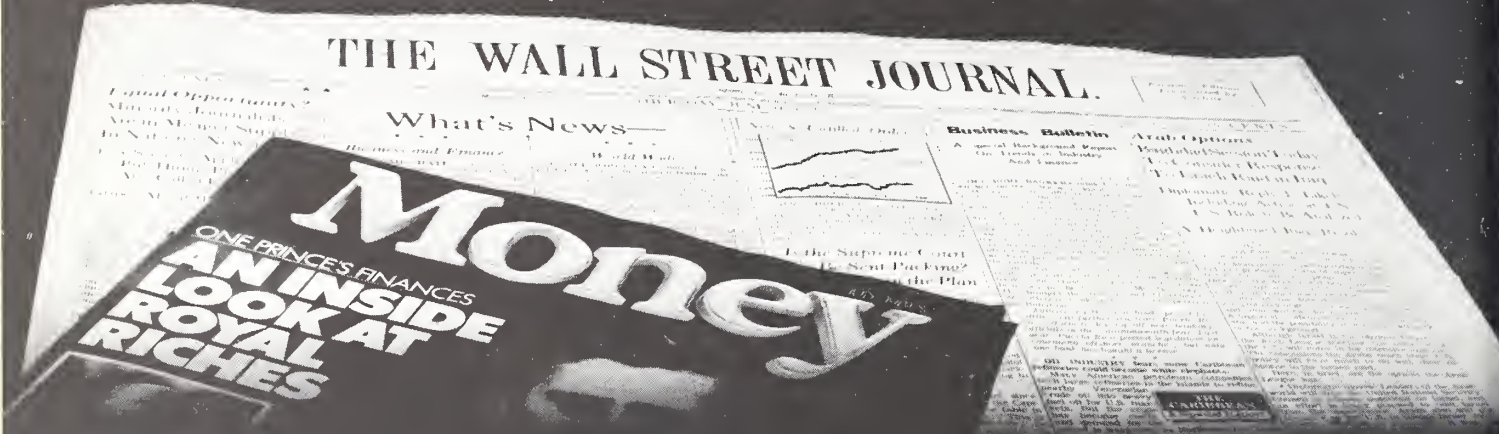
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Clinical Notes

(continued from page 723)

Exertional headaches (cont.)

performing leg presses. There was no vomiting, weakness, paralysis, change of vision or sensation. Pain was somewhat relieved by aspirin. The patient experienced the same headache while performing leg presses on the evening of admission. He left the fitness center and came to the emergency room.

The headaches fit the characteristics of the benign, exertional headache. This type of headache is unique in that its onset is prompt; it occurs with physical activity; is brief in duration and is generally diffuse, especially when severe.

The prognosis for this malady is good. The patient studied has resumed his weight training. The headaches occur only on maximal effort with maximal weight. Also, it

has been found that a course of indomethacin 25 mg. three times a day with meals may help.

Because of the number of people engaged in personal fitness and, to a lesser extent, weight training, the benign exertional headache may be found with some regularity.

Annals of Emergency Medicine
August, 1982. Volume 11, No. 8
pgs. 449-451

Attitudes of hyperactive children

Little currently is known about how hyperactive children feel toward stimulant drug treatment, or how to find out how they feel.

In this report, the authors interviewed 52 children, diagnosed hyperactive, and examined their responses in light of information provided by parents and teachers.

Above all else, the authors found a

pervasive dislike among hyperactive children for taking stimulants, for a variety of reasons. Most felt they did not need the medication; a number suffered from physiologic side effects (anorexia, stomach ache, insomnia); others noted the change in the perception of self, depression, decreased ability in gym class, and the drugged feeling brought on by the medication.

One device used is to stop medication and agree not to restart as a goal (and reward) for continued satisfactory performance. Regardless of the techniques used, it is important for the clinician to understand any distress or confusion the child may be experiencing and to enlist his or her cooperation in structuring the medical regimen so as to aid in developing new behavior patterns.

Clinical Pediatrics
August, 1982. Vol. 21, No. 8
pgs. 474-479

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Brief Summary
Consult the package literature for prescribing information.

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms:

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor.

Contraindications: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES. Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of ceclor may result in the overgrowth of non-susceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics. In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy: Although no teratogenic or antenatal effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in fetuses given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy: Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to ceclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2-5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 90).

As with other broad-spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Ceclor.

Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.⁷

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Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor® (cefaclor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic: Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic: Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal: Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[1002818]

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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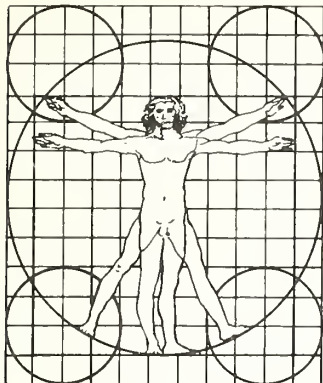
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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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CLINICAL & SCIENTIFIC

FIFTY YEARS OF SURGICAL EDUCATION AT AKRON CITY HOSPITAL

C. William Loughry, M.D., F.A.C.S.

The record of 50 years of continuous approval of a surgical residency and the record of its graduates is presented. The use of nonindigent patients and volunteer surgeon education is emphasized.

THE USE OF PRIVATE PATIENTS in surgical residency education has received considerable attention by both the lay media and surgical educators.¹ This is so because of the decrease in the number of nonprivate patients and the need to use such private cases in surgical education. The problems created by this, particularly in traditional Halsteadean residency systems, are many and have led to many different ways of evaluating its effect on the patient as well as the quality of education received by the resident.

One of the time-honored ways of evaluation in medicine is a study of past records. This paper is an evaluation of the record and development, over the past 50 years, of one surgical residency with a patient population that has been largely (85%) private and its relationship to the accrediting process.

If such a program is to be successful, it must demonstrate that it continually has met the standards of residency accrediting agencies and that it has produced competent surgeons.

The surgical residency at Akron City Hospital has met this challenge for the past 50 years because of its commitment to graduate medical education.

On May 27, 1930, the Council on Medical Education and Hospitals of the American Medical Association published in the Journal of the American Medical Association, a list of

"Hospitals Approved for Residencies in Specialties."² The list was prefaced by this statement: "The following hospitals containing 203,850 beds are considered in position to furnish acceptable residencies in the several specialties designated, for graduates who already have had a general internship or its equivalent in practice."

This approval was for a three-year surgical program and was to prove sufficient for examination by the American Board of Surgery which was not established until 1936. It also qualified the graduate for fellowship in the American College of Surgeons.

In 1930, there were 113 hospitals approved for residencies in surgery offering only 261 resident positions.² Today, there are 352 surgical residencies for 7,968 resident positions.³ In Ohio, there were nine approved surgical residencies in 1930. Six of these were in Cleveland, two in Cincinnati, and Akron City Hospital. Of the original nine, only seven including this program, have had continuous approval for 50 years.

The hospital's commitment to medical education began shortly after its founding in 1892. This is documented by its inclusion on the first list of approved internships published by the American Medical Association (AMA) in 1914. Thus began the tradition which prevails today: the education of residents utilizing private cases by the hospital's surgical staff who participate as teachers without pay.

Akron City Hospital's continuous record of success in surgical education is related directly to these dedicated people who have willingly shared their expertise over the years with residents in their preparation for professional practice. One such surgeon was Carl R. Steinke, M.D. (1883-1946), who joined the hospital staff in 1915. He was a graduate of the University of Pennsylvania, and received his surgical training at the Mayo Clinic. His deep interest in medical education was to play a significant role in the evolution of the hospital's surgical residency programs and the high ethical standards of surgical practice in Akron. Steinke was instrumental in formulating an organized approach to surgical education and training. In the early years, these programs consisted mostly of hard work

Dr. Loughry, Akron, Chairman, Department of Surgery, Akron City Hospital; and Professor of Surgery, Northeastern Ohio Universities College of Medicine, Rootstown, Ohio.
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with the only scheduled conferences being monthly medical staff scientific meetings and weekly tumor conferences. The remaining instruction was preceptorial and was irregularly given in surgery and on occasional ward rounds. The pioneering efforts of Steinke and his colleagues were contributing factors to the AMA's inclusion of Akron City Hospital's surgical residency program on the 1930 list.

In 1932, efforts to broaden the scope of surgical education led to an affiliation with the Graduate School of Medicine of the University of Pennsylvania. This afforded Akron City Hospital residents a nine-month didactic course of study which consisted of basic science and clinical surgery and led to a master's degree in medical science (M. Sc. med.). This affiliation continued until 1965, when the hospital was able to meet the requirement of the Conference Committee on Graduate Training in Surgery, ie, that the basic sciences be integrated into the clinical aspects of a surgical program.

In 1939, the American College of Surgeons assumed the role of approval of surgical training nationally and published its first list of hospitals for graduate training in surgery.⁴ This list was published under the following quotation:

"Nine years ago, the American College of Surgeons began a study of graduate training which approaches culmination with the publication in this issue of the *Bulletin* of the first list of hospitals approved for graduate training in general surgery and/or the surgical specialties. This list furnishes a definite starting point for a new effort to make the list of hospitals approved for graduate training as significant and stimulative in this particular field as the Approved List of Hospitals has been throughout the hospital field as a whole."⁴

Akron City Hospital was one of ten in Ohio on that list and one of 115 in the United States and Canada. It is interesting to note the requirements for approval listed in the *Bulletin* of April, 1939, were not dissimilar to those of today: that the medical staff be well organized, that there be assigned personnel responsible for supervision and direction of the resident staff, that departmental conferences in general surgery and the surgical specialties be held at least weekly, that an active surgical service exist with sufficient numbers of patients, as well as an outpatient department with systematic follow-up clinics. Although not specifically stated, it was implied that there was a carryover of a statement by the House of Delegates of the American Medical Association in 1923, that one of the most important features of a postgraduate program is the gradual upgrading of responsibility of the resident under competent supervision.⁵

Basic Science Education

The College also recognized the need for basic science education in a surgical program. It did not, however, require it be integrated in clinical practice, but specified it could be obtained by affiliation with formal educational programs in basic sciences at cooperating medical schools. The program at Akron City Hospital obviously met this qualification because of its affiliation with the Graduate School of Medicine of the University of Pennsylvania.

In 1950, the Conference Committee on Graduate Training in Surgery, the newly designated accrediting body, granted Akron City Hospital approval for a four-year surgical training program after the completion of an acceptable internship which accounted for the full five years.

In 1975, accreditation responsibility was transferred to the Liaison Committee on Graduate Medical Education. Akron City Hospital, at that time, received accreditation for a five-year program incorporating the first postgraduate year into the entire program, as recommended by the Millis report.⁶

While the program in surgery was growing, related specialties also were developing. A residency in orthopedics was approved at Akron City Hospital in 1948. Two years later, similar

programs were established in OB/GYN and urology. During the late '60s and early '70s, ophthalmology and plastic surgery were added to the list of residency programs at Akron City Hospital. There now are six surgically related residency programs at the hospital.

The scope of surgical education at Akron City Hospital was broadened considerably in 1972, when the hospital became affiliated with the Ohio State University College of Medicine. Since that time, 94 Ohio State medical students have served clerkships in surgery at the hospital.

Two years ago, the hospital's surgical training program was further expanded by affiliation with the newly formed Northeastern Ohio Universities College of Medicine. Thus, for the first time, the hospital could lay claim to a true university affiliation. The Department of Surgery, along with other clinical disciplines, serves as a major resource for the education of clinical clerks from the College, under the guidance of the hospital's own surgeons who serve as faculty. The first group of clinical clerks joined this program last year.

Today, the residency in general surgery provides education for 15 residents with three admitted each year to the five-year program. All residents are graduates of American medical schools and seven such institutions are represented in the present group.

In-house Training

In contrast to its early beginnings, the entire program is conducted at the hospital. The extent of surgical training at Akron City Hospital today is indicated by the fact that there are 54 residents in six disciplines, having developed from the approval for the original two in 1930. The formal education program now includes 38 weekly conferences. There are approximately 16,000 surgical procedures performed annually, providing residents with a more than adequate operative and clinical experience.

Akron City Hospital's half century of success in surgical residency training can be attributed to three major factors. One of these, as stated earlier, is the dedication of a group of volunteer clinical teachers committed to education in surgery. A tangible illustration of these is the number of professional papers authored by members of the Department of Surgery. Since 1909, 23 of these men have published 273 scientific papers, most of them during the past 50 years.

Another factor directly related to the first, is the hospital's consistent ability, over 50 years, to attract as residents graduates of medical schools in the United States and Canada. Since 1969, when the Department began accepting graduates in the first postgraduate year, the Department of Surgery has filled its quota 100% of the time, and is the only hospital in Ohio to do so.

The third factor in this success has been the sound financial position of the hospital and its willingness and ability to support graduate medical education.

Akron City Hospital looks back with pride on its 50 years of surgical residency education. The uniqueness of the program and the dedication of those involved have produced an impressive record. Of the 84 men completing the program, 72 are American medical school graduates who have an American Board of Surgery certification rate of over 82% and a total program certification rate of 77%.

The program has made a significant contribution to the quality of health care in Ohio. Fifty-four graduates are now practicing in Ohio — many in smaller towns and rural areas — and the remainder, in 20 other states and three foreign countries.

In addition to the general surgery residency, 173 residents in other surgical specialties have completed their education here and are in practice throughout Ohio, the United States and abroad.

The continued success of this residency demonstrates that a

lack of large numbers of nonprivate cases in a surgical program need not be a handicap. This is important because, in a society structured as it is in this country today, the education of surgeons for the future on a large indigent patient population is a thing of the past.

It also is important to note that the program has now completed its first year of the education of clinical clerks with the same patient population and has done so without any significant problems. This undoubtedly was possible specifically because of over 50 years' experience in medical education utilizing nonindigent patients.

In the final analysis, the success of this program in graduate surgical education is directly related to people — volunteer surgeons who are dedicated to their profession and whose only reward is a sense of pride and accomplishment in the participation of the education of surgeons to follow them.

An evaluation of this program indicates:

1. It has stood the test of time for the past 50 years by continuously meeting the standards of residency accreditation.

2. The test of competence for individual surgeons by achieving a certification rate from the American Board of Surgery of 77% overall and 82% for graduates of American medical schools.

In summary, the author has presented the history of graduate training in surgery over the past 50 years at Akron City Hospital. The program has essentially been a private, nonaf-

iliated residency. The history of the program is related to the significant developments of the accreditation of graduate surgical education throughout those 50 years. The reasons for the success and the factual documentation of the program are included in the report.

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Pyridoxine HCL (B-6) 10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

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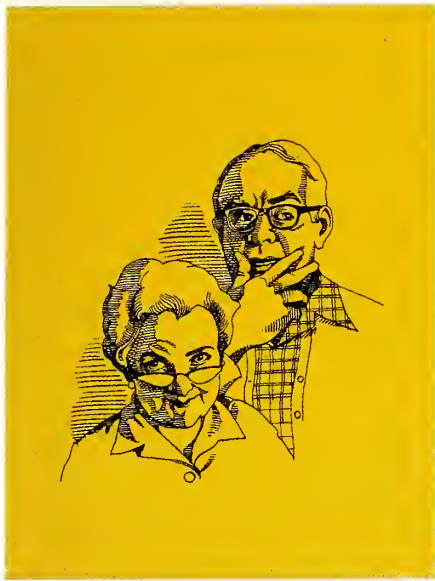
Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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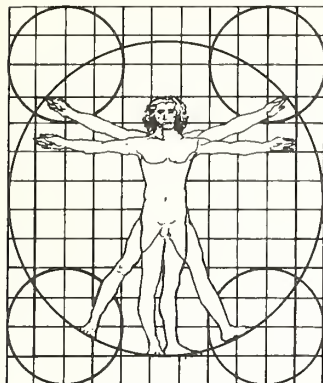
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CLINICAL & SCIENTIFIC

HELIUM-OXYGEN MIXTURES AS ADJUNCTIVE SUPPORT FOR REFRACTORY VIRAL CROUP

Donald S. Nelson, M.D.
Larry McClellan, R.R.T

Helium is a chemically inert gas of low density which can be substituted for nitrogen in oxygen mixtures, greatly decreasing the force required to move respiratory gases through airways with turbulent flow. Fourteen patients with viral croup between the ages of three months and 21 months (average 10.8) were given O₂ - 20% - 30%, helium - 80% - 70% as adjunctive therapy. In 11 of the 14 patients, comments on the charts by nursing personnel indicated sleep or a restful state. All were improved and none of these patients who were severely jeopardized required intubation or tracheotomy.

THE TREATMENT OF REFRACTORY viral croup by racemic epinephrine has greatly improved results in most patient series.¹ We have not been able to achieve a desired result for every patient, but have found helium-oxygen mixtures to ease breathing effort and to be valuable adjunctive support for otherwise refractory viral croup.

Helium Therapy

A nitrogen 79% - oxygen 21% (air) mixture has a density of 1.293 g/l; helium 80% - oxygen 20% has a density of 0.429 g/l; and helium 70% - oxygen 30% has a density of 0.554 g/l.² For upper airway obstruction with rapid gas flow and increased turbulence, decreased density lessens the force required to move respiratory gases.³ The report of beneficial effects of helium-oxygen mixtures for upper airway obstruction by Duncan stimulated our interest in the value of this mixture as an adjunctive therapy for refractory viral croup.⁴

Method

Fourteen patients between the ages of three months and 21 months (average 10.8 months) constituted our observed series. The patients were all admitted with the diagnosis of viral croup and all had barking coughs, flaring of nostrils, sternal retraction, and use of accessory muscles of respiration. All were treated with humidified air or oxygen-enriched air and racemic epinephrine by the method described by Adair; et al, without significant results.¹ An average of 7.4 treatments were given. Continued concern resulted in an anesthesia consult for possible intubation or tracheotomy. The anesthesiologist placed all reported patients in ICU and with close observation recommended a trial of helium-oxygen mixture.

Results

All patients were observed to be in less distress immediately. The cough, while still barking, was not as distressing. Flaring of nostrils, sternal retractions, and use of accessory muscles of respiration were improved. In 11 of the 14 patients, comments on the charts indicated sleep or a restful state and great improvement from their previous condition. In no instance did a patient deteriorate. Average time receiving helium-oxygen mixture was 25.4 hours with extremes of 12 to 69 hours. Blood

Dr. Nelson, Akron, Chief, Department of Anesthesia, Children's Hospital Medical Center of Akron; and Associate Professor of Anesthesia, Northeastern Ohio University College of Medicine. Mr. McClellan, Akron, Assistant Director, Respiratory Therapy Department, Children's Hospital Medical Center of Akron. Submitted July 15, 1981.

gases for all patients were obtained shortly after initiation of therapy and all were within normal limits. If after initial improvement any return of symptoms was noted, racemic epinephrine by intermittent positive pressure breathing was given and the patient returned to the helium-oxygen atmosphere. An average of 2.1 treatments were given during helium-oxygen therapy.

Comments

Helium is a chemically inert gas of low density (only chemically active hydrogen is lower), which can be substituted for nitrogen in oxygen mixtures, greatly decreasing the force required to move oxygen through airways with turbulent flow. Refractory viral croup is advantageously treated with helium-oxygen mixtures. Any interruption of the helium-oxygen mixture and a return to air will cause a return of the original symp-

toms. All patients should be nursed under close observation (in our hospital the intensive care unit) and means for an artificial airway immediately available.

References

1. Adair JC, Ring, Jordan WS, et al: Ten year experience with IPPB in the treatment of acute laryngotracheobronchitis. *Anesth Anal (Cleve)* 50:649-655, 1971.
2. Egan DF: Fundamentals of respiratory therapy. 3rd edition, C.V. Mosby, 1977, pp 316-319.
3. Barach AL: The therapeutic use of helium. *JAMA* 107:1273-1279 (1936).
4. Duncan PG: Efficacy of helium-oxygen mixtures in the management of severe viral and postintubation croup. *Canad Anaesth Soc J* Vol 26, No. 3, May, 1979.

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The Troubleshooter

(continued from page 681)

he and his colleagues. He sits on the OSMA Committee on Education and was recently selected to be editor of its CME Procedure Manual. In addition, he serves as a CME Consultant for Network for CME, a national group which produces CME tapes.

Dr. May is also concerned about the educational requirements of two other widely divergent groups: physicians' assistants and priests. When speaking recently at the American Academy of Physicians' Assistants national meeting, he told the PAs that their greatest challenge in the '80s would be to stay viable with the predicted oversupply of physicians.

While priests don't really have to worry about an oversupply, their educational needs are of concern to Dr. May. He was recently asked by the President of the Board of Examining Chaplains and the Board for Theological Education of the Episcopal Church of the United States to prepare a study guide to help graduates of the Episcopal Seminary School to prepare for their General Ordination Examination.

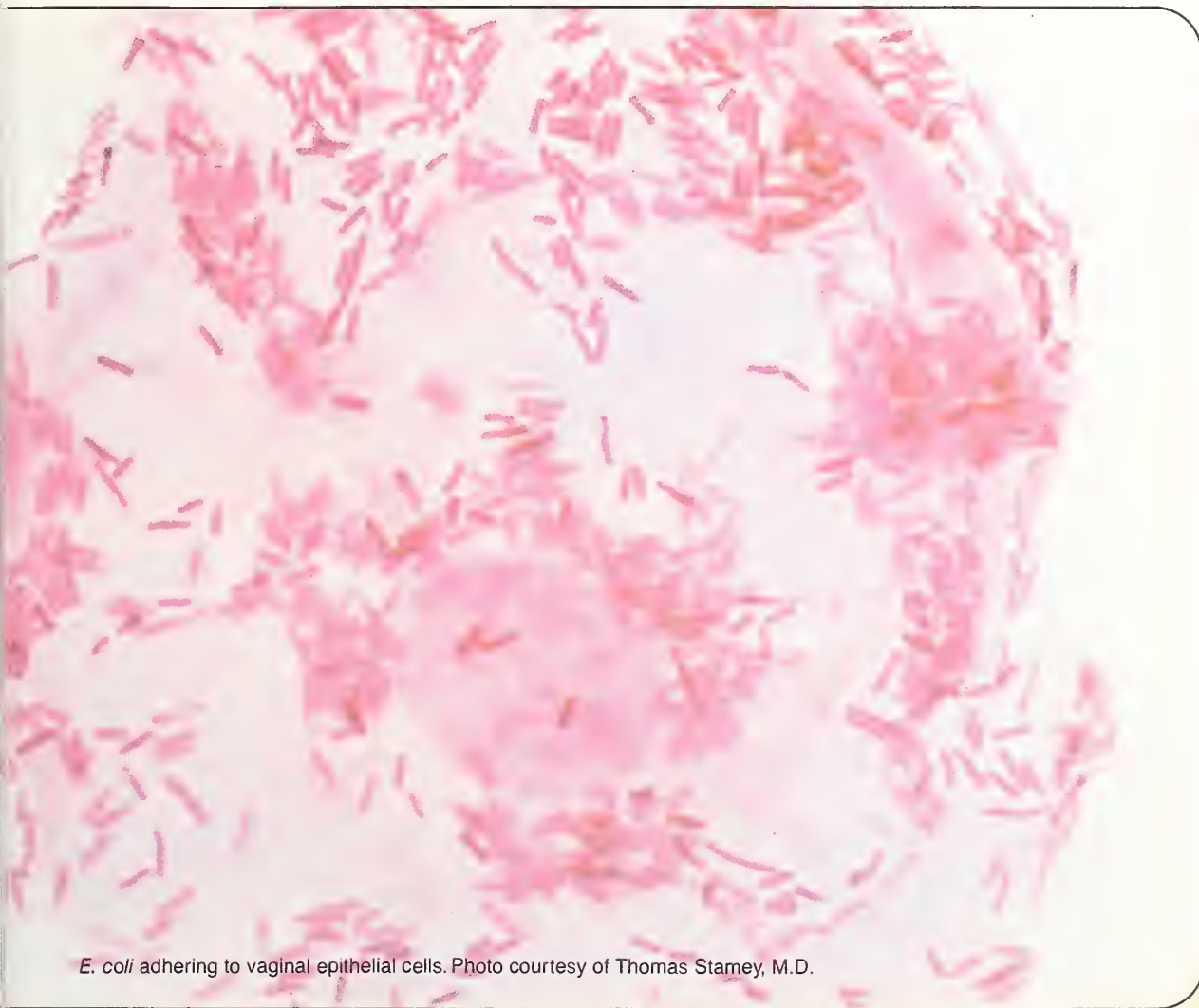
In other words, Dr. May is a very busy man. But he is quick to say it is the type of involvement that keeps him interested and keeps his enthusiasm up. "Every time I get involved in a project that takes me away from Marion or takes me away from my practice, I am always ready to go back in a few days."

It is a philosophy that has also been adopted by his wife, Ingrid. Besides being very involved in the local, state and national auxiliary, last year she took over the task of teaching German in the local high school when the school was faced with the prospect of having its German program end when its teacher left.

So if things occasionally get a little hectic at the May household, it is well worth it to both Dr. and Mrs. May. "It helps keep our perspective fresh."

Carol Wright Mullinax is the Associate Director, Department of Communications.

cling to receptors



E. coli adhering to vaginal epithelial cells. Photo courtesy of Thomas Stamey, M.D.

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Second Opinion

(continued)

Should it be impossible for physicians to admit that we haven't known all the answers — and still don't?

control groups given no sedation at all. All this can be well-substantiated in the medical literature. Nobody is keeping these things secret. Why then, do we still see all these practices continued?

Why indeed. I suspect that it is basically just a reluctance to change,

and possibly that this change would mean we would have to admit that we had been wrong all along about these things. Tough to do, but should it be impossible for physicians to admit that we haven't known all the answers — and still don't? I admit straight out that some of the modern practices may be wrong; but all the current evidence points the other way. Show me some evidence that hypnotics are useful, aside from Aunt Minnie's claim that she can't sleep without them (of course not, she's habituated to them!), and I will apologize. Show me a controlled trial where diet affected an ulcer. Show me where narcotics and tranquilizers decrease the frequency or severity of headaches or other benign chronic pain syndromes. Come on, let's see some evidence!

I bet there are lots of outmoded practices that we are all still following — myself included. Let's root them out and get them publicized — and then let's resolve to change our ways! We have nothing at all to lose. Patients will not stop coming to us because we have learned something new, though

it may take a little work to convince Aunt Minnie that we can taper off her secobarbital and she will end up sleeping as well and probably better. And we have lots to gain: healthier patients, lower medical bills — why, we might even entice the drug companies into doing something more useful than producing another minor tranquilizer!

Homo sapiens' biggest evolutionary improvement was that he could think and remember better than his predecessors. Our next evolutionary improvement may be an ability to forget old nontruths better than our predecessors. With just a little honesty and forthrightness, we doctors can lead the way into the new millenium, perhaps even encouraging our patients — and who knows, maybe even politicians — into following, and thereby avoiding the fate of the dinosaurs.

Brooks A. Mick, M.D., a member of the OSMA, practices internal medicine in Findlay, Ohio.

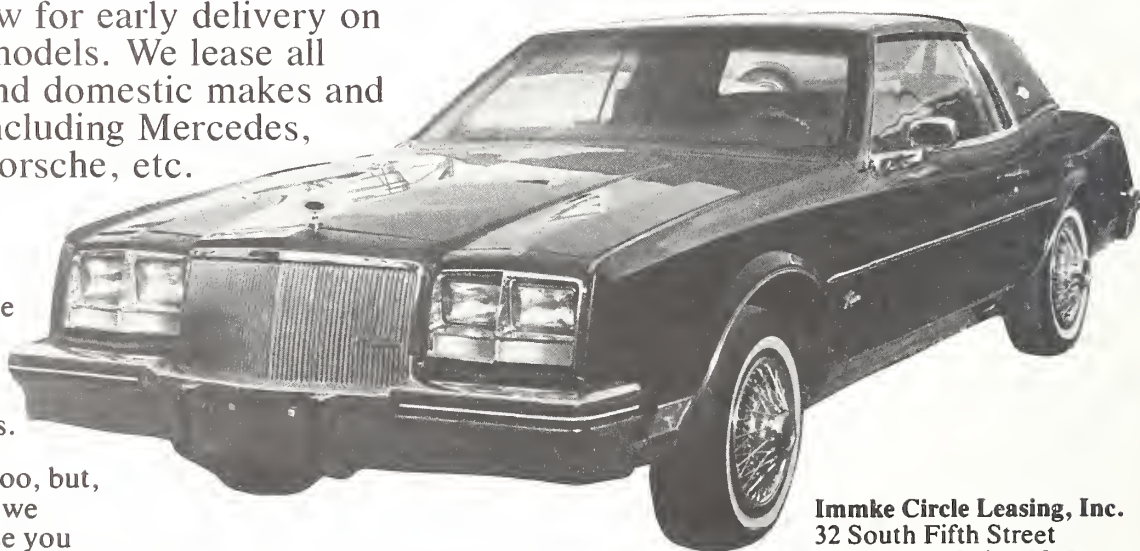
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COLLEAGUES IN THE NEWS



ROBERT AUSDENMOORE, M.D., Cincinnati, was elected president of the medical dental staff of Children's Hospital Medical Center. Dr. Ausdenmoore is a pediatric allergist. Also elected were **DANIEL FRIEDBERG, M.D.**, vice-president, and **JOHN NOSEWORTHY, M.D.**, secretary-treasurer.

RONALD BERGGREN, M.D., Upper Arlington, was elected director of the American Board of Plastic Surgery. He also was elected treasurer of the American Association of Plastic Surgeons. Dr. Berggren is director of the Division of Plastic Surgery at Ohio State University Hospitals, professor of surgery at the Ohio State College of Medicine, and director of the Division of Plastic Surgery at Children's Hospital in Columbus.

JOHN BISKIND, M.D., Solon, was appointed director of the division of obstetrics and gynecology at Hillcrest Hospital. Dr. Biskind is a specialist in obstetrical and gynecological medicine.

BLAINE L. BLOCK, M.D., Dayton, was elected president-elect of the Ohio Society of Otolaryngologists.

FRANK E. FOSS, M.D., Sylvania, is the new president of the American Heart Association's Northwestern Ohio Chapter, and **RICHARD F. LEIGHTON, M.D.**, was elected vice president.

RAY W. GIFFORD, JR., M.D., Cleveland, was presented with the Simon Rodbard Memorial Lecture Award, at Convocation ceremonies of the XIV World Congress on Diseases of the Chest, held in conjunction with the 48th Annual Scientific Assembly of American College of Chest Physicians, in Toronto, Canada. Dr. Gifford is head of the department of hypertension and nephrology at the Cleveland Clinic Foundation in Cleveland, Ohio, and has authored and edited numerous articles and publications. He is the recipient of numerous other awards, including the OSMA's Randolph Gerlinger Memorial Lecture Award.

ARTHUR J. HORESH, M.D., Cleveland, was appointed to the editorial board of the International Correspondence Society of Allergists.

SCOTT INKLEY, M.D., Hunting Valley, was appointed president and chief executive officer of University Hospitals of Cleveland. Dr. Inkley, a lung specialist, is a professor of medicine at the Case Western Reserve University School of Medicine.

An article by **M. BRODIE JAMES, M.D.**, Perrysburg, was featured in a recent issue of *Medical Economics*. The article entitled, "How I Learned to Love My 'Historic Office,'" told of his experiences renovating a Victorian mansion and turning it into a place to house his active dermatological practice. Dr. James incorporated the decor and nostalgia of the Victorian period into his office layout, creating an unusual, yet efficient place in which to treat his patients.

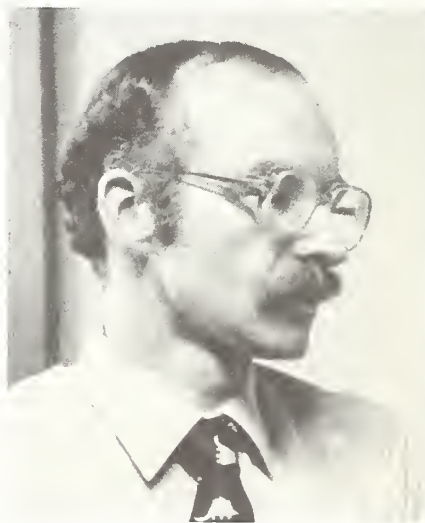
continued on page 741



Ronald Berggren, M.D., Columbus . . . new director, American Board of Plastic Surgery.



Ray W. Gifford, Jr., M.D., Cleveland . . . recipient of the Simon Rodbard Memorial Lecture Award



Leonard J. Janchar, M.D., Marion . . . Community MedCenter's new chief of staff

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Colleagues

(continued)

LEONARD J. JANCHAR, M.D., Marion, was elected chief of staff at Community MedCenter Hospital. Dr. Janchar specializes in pediatrics.

FRANK H. KRAUTTER, M.D., Youngstown, was named an associate director of the family practice center at the Youngstown Hospital Association.

MYUNG S. KWAK, M.D., Medina, was appointed assistant professor of psychiatry at the North East Ohio University College of Medicine in Rootstown. Dr. Kwak is a practicing psychiatrist for the community Mental Health Services of Medina County, Inc., and recently opened her own private practice in Medina.

JOHN F. KRONER, JR., M.D., was elected chief of staff of O'Blenness Memorial Hospital in Athens.

RAYMOND A. KIWALA, M.D., Middleburg Heights, was installed as president-elect of the Ohio Academy of Family Physicians. Dr. Kiwala is a clinical assistant professor in the family medicine department of Case Western Reserve University School of Medicine.

JANICE SLADKY LLOYD, M.D., Perrysburg, was named director of the Bowling Green State University Health Center.

WATSON PARKER, M.D., Dayton, was appointed to serve on the Medical Advisory Board of the Western Ohio Chapter, National Multiple Sclerosis Society.

BUEL S. SMITH, M.D., Akron, was appointed professor of orthopedic surgery and chairman of the Council of Orthopedic Surgery at Northeastern

Ohio Universities College of Medicine. Dr. Smith is chairman of the department of orthopedic surgery and director of the Residency Training Program at Akron General Medical Center.

CHARLES W. WILSON, M.D., Marion, was honored for his 30 years of service at the Frederick C. Smith Clinic. Dr. Wilson, an internist, joined the clinic in 1952 and established a radioactive isotope laboratory at the clinic in 1953.

FREDERICK G. WINEGARNER, M.D., was elected chief of staff of Marion General Hospital's medical staff. Dr. Winegarner is a general and peripheral vascular surgeon. Also elected were **PAVANENDER GUPTA, M.D.**, radiologist, vice chief of staff, and **EDWIN G. DAVY, M.D.**, radiologist, secretary-treasurer.

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**edited by
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PAAD to assist parents of troubled youths

Parent Alert Against Drugs (PAAD) is a new program, designed by the Department of Economic and Community Development, to assist in finding statewide alcohol and drug abuse resources for parents of troubled youth.

By calling their toll free number (800-282-9254), parents can be provided not only with accurate, up-to-date alcohol and drug literature, but access to the only Ohio directory of substance abuse services for adolescents, as well — services which include prevention, crisis intervention, family support, aftercare, treatment and model programs for community planning.

PAAD's major goal is to assist in linking persons in need to the services open to them. For more information on the program, contact D. Jeanne Roberts, Coordinator, Parent Alert Against Drugs, Department of Economic and Community Development, P.O. Box 1001, Columbus, Ohio 43216.

Diagnosis of diabetic retinopathy may be missed by many physicians

Diabetic retinopathy, the leading cause of adult blindness in the United States, can be arrested if recognized and treated early enough. But in more than 60 percent of cases, diagnosis of the disease may be missed by the physicians who care for most diabetic patients, according to statistics from a Pennsylvania study reported in a recent issue of the *Journal of the American Medical Association*.

The cause of diabetic retinopathy is unclear, but physicians believe that the degenerative process begins early in the course of the diabetes and develops for years before becoming clinically apparent. The earliest signs include tiny balloon-like dilations called aneurysms on the retinal blood vessels and minute hemorrhages that result when the aneurysms rupture. A more advanced stage termed proliferative retinopathy is marked by the formation of new retinal blood vessels, often in an uncontrolled, spaghetti-like tangle, which can hemorrhage into the vitreous humor, the gel that fills the interior of the eyeball. The final consequence can be partial or total blindness.

Elliott J. Sussman, M.D., assistant professor of medicine at Hospital of the University of Pennsylvania, and colleagues, report that internists missed 52 percent of the diagnoses of proliferative retinopathy, residents missed 50 percent, diabetologists missed 33 percent, and general ophthalmologists missed 9 percent, while retinal specialists did not miss any. It is at this stage of the disease that treatment by laser photocoagulation of the proliferating blood vessels can reduce the risk of progressive loss of vision, according to Jay S. Skyler, M.D., associate professor of medicine and pediatrics at the University of Miami School of Medicine.

Because diabetic retinopathy develops slowly in juvenile-onset

insulin-dependent diabetics, ophthalmologic examinations rarely reveal the disease in the early years. Dr. Skyler says these patients should be examined yearly for retinopathy, initially by the primary physician. After about eight to ten years, or earlier if there is suspicion of retinopathy, the examinations should be performed by an ophthalmologist. In older patients who develop diabetes, the examinations should begin about four to eight years after onset of the disease. Diabetics should seek routine eye care from an ophthalmologist rather than an optometrist, Dr. Skyler says.

He notes that primary care physicians can help reduce the risk of diabetic retinopathy by helping patients to maintain normal blood sugar level and to control hypertension.

Kick the "turtle" habit

Early morning headaches can plague sleepyheads who bury themselves beneath the blankets to catch a few more winks.

In a recent issue of the *Journal of the American Medical Association*, Gordon J. Gilbert, M.D., of St. Petersburg, Florida, explains that a bilateral headache, probably due to a lack of oxygen and build-up of carbon dioxide in the blood, can result when the sleeper pulls the bedcovers over his head or retracts his head under them in order to avoid daylight and go back to sleep.

Discovering the "turtle" habit could be important in avoiding permanent neurological damage from a recurrent oxygen deficit in the brain, Gilbert says.

"The Elephant Man" may have suffered additional disorders

New evidence has come to light, revealing that Joseph Carey Merrick, the British man known as "the Elephant man," who died of neurofibromatosis at the age of 29 in 1891, may have suffered from other conditions besides the genetic disorder responsible for many of Merrick's bizarre and misshapen physical characteristics.

A bone disorder, known as fibrous dysplasia in which the outer layers of bone become thin, and the marrow gradually replaced by gritty, fibrous

material, contributed to Merrick's deformity, as did fibrous overgrowths in the skull and face that particularly distorted the right side of his face. His left hip also was severely deformed, probably resulting from localized tuberculosis, or a form of arthritis in which pus fills a joint cavity.

These disclosures followed examinations of x-rays by Benjamin Felson, M.D., professor of radiology at the University of Cincinnati Hospitals. The x-rays are believed to be the first ever taken of Merrick's remains.

The newly unearthed findings about the Elephant man were largely the result of the historical sleuthing of William B. Bean, M.D., Sir William Osler, professor of medicine at the University of Iowa Hospitals and Clinics in Iowa City.

Although casts of the body surface are available, Merrick's neurofibromatosis had never been microscopically confirmed. When the x-rays were examined by Felson, the additional bone disorders were discovered.

Notice to All OSMA Members

Your Membership in the Ohio State Medical Association and American Medical Association, including subscriptions to *The Ohio State Medical Journal* and *The Journal of the AMA*, will expire on December 31, 1982. Here's how to renew:

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The member who becomes eligible for exemption from dues, because of retirement or disability, should notify the Secretary-Treasurer of his/her County Medical Society. After exemption has been established, it will be renewed annually unless the status changes.

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El Greco of Toledo

By James G. Ravin, M.D.

The first major exhibition devoted to the paintings of El Greco will be shown this year at the Toledo, Ohio Museum of Art. It will include the largest number of paintings by the first great Spanish painter ever shown together. The exhibition also will be shown at the Museo del Prado in Madrid, Spain, the National Gallery of Art in Washington, D.C., and the Dallas, Texas Museum of Fine Arts.

El Greco's art is of interest medically. The normal effects of aging on his style can be seen. Colors changed and details became less apparent with the progress of time. The largely discredited hypothesis that El Greco's unique style was due to an ocular abnormality is also worthy of consideration.

THE ARTIST

El Greco (1541-1614) was the first great Spanish painter. His real name was Domenikos Theotokopoulos, but he is referred to by the nickname El Greco ("the Greek"). He was born on the Greek island of Crete, trained in Italy, and spent the last half of his life in Spain.

Little is known about his early years on Crete. Apparently his family was wealthy and socially prominent. He was trained in the Byzantine style of icon painting there. The elongated figures typical of icons eventually became an important feature of his mature style. At about age 18 El Greco moved to Venice, where he spent ten years. Venice controlled Crete at that

The Venetian use of bright colors and movement became features of his art

time, and the Italian city was the home of thousands of Greeks. Venice was then at the peak of its glory as the artistic center of Italy. Titian, Tintoretto, and Veronese all were painting actively and El Greco learned from each of them. He must have found the Venetian use of bright colors, dramatic light, and movement appealing, for they became features of his own art.

In 1570 he moved to Rome, where he saw the paintings of Raphael and Michelangelo. The nudes in Michelangelo's "Last Judgment" offended some people, so that repainting the figures was suggested. El Greco reportedly said that he could have redone the painting "with honesty and decorum" and in "good quality." He also is quoted as saying "Michelangelo was a good man, but he did not know how to paint."¹ But El Greco had great respect for Michelangelo as a draftsman. He also saw the paintings of Parmigianino, who was a virtuoso in the Mannerist style. His works are characterized by graceful, elongated figures and ambiguous space, features which appealed to El Greco.

When and why he left Italy for Spain are not known. The plague of 1575 or the epidemic of the following year which killed Titian may have influenced him. In Rome he was at the center of intellectual circles, and he made contacts that most likely helped when he went to Spain. He certainly was aware that Spain was the most powerful country on earth and that its ruler, Philip II, sought artists to

DESCRIPTION: Methyltestosterone is 17 β -Hydroxy-17-Methylandroster-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunuchism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptorchidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric,

avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

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El Greco of Toledo

(continued)

decorate his new palace and monastery, the Escorial. By 1577 he was in Spain. He apparently painted only one work for the king. After Philip rejected it, El Greco received no further royal commissions. But he was a popular artist. The church appreciated his humanistic and spiritualistic treatment of Counter-Reformation themes. The many copies of his work done in the 17th century also attest to his popularity.

After he moved to Spain, El Greco's style reached its heights. His elongated figures are often isolated and exist in a strange type of space, nearly floating. This emphasizes the celestial quality of the scenes that otherwise seem so earthly. The lighting is an eerie white, ghost-like, and evokes a strong emotional response in many viewers. This unique, original style was controversial from the beginning. El Greco did not satisfy Philip II, who preferred conventional, mediocre artists, but he gained much fame in Toledo. The artist and author, Pacheco, said he was "singular in everything as he was in his painting." He also was involved in litigation over the religious interpretations of his paintings and the fees he demanded.



"Christ Cleansing the Temple," (above) is rich in both detail and color. His later painting, "The Purification of the Temple" (below) shows a noticeable loss of details and — although not noticeable here — a change in colors. The change is more likely to be attributed to age rather than to the astigmatism from which many felt the artist suffered, however. (Photographs of paintings courtesy of the Toledo Museum of Art.)

His elongated figures often are isolated and exist in a strange type of space, nearly floating

El Greco's art always has been popular in Spain, but he did not acquire an international reputation until this century. Interest in his work was rekindled in the 1840s in France when an exhibition of his work was held at the Louvre. Delacroix, Millet, and Degas owned his paintings; Cezanne and Sargent copied him. Americans became more aware of his work after the first book in English



continued on page 751

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El Greco of Toledo

(continued)

devoted to his art was published early in this century. Not every critic found his art appealing. One author described his painting in *Art News* as a "jumble of carelessly thrown together, badly drawn human figures not worth fifty dollars."² Today most critics admire the dramatic lighting, bright colors and movement of his figures.

ASTIGMATISM?

El Greco's style was so original that it shocked many observers. Some people thought he must have been mad, though all surviving records indicate he was perfectly sane. Others suggested he had an ocular defect, astigmatism. El Greco is not the only artist who has been called astigmatic. Holbein, Cranach the elder, Botticelli, Titian, Modigliani, and Sargent also have been placed in this category.³ Astigmatism is an optical abnormality in which light rays from a single point are not focused at a point on the retina, but are spread out as a line in one direction.

The arguments in favor of the astigmatism theory may be summarized as follows:

1. Artists sometimes distort objects in one direction. If an astigmatic lens is placed over one eye of an artist and he is asked to draw a circle, he will draw an ellipse.

2. If an astigmatic lens is used to view an El Greco painting, the abnormal elongation of his figures can be made to disappear.

The arguments against the theory⁴ are:

1. Elongation in El Greco's art is purely stylistic. He was influenced by the elongated figures of Byzantine art and the distortion of the Mannerist style of painting.

2. If an artist has astigmatism, elongation should occur in only one direction. But the distortion of El Greco's figures occurs in both the horizontal and vertical directions. Most bodies are stretched vertically yet have fingers stretched horizontally. If astigmatism were the cause of the

Toledo's El Greco exhibit

"El Greco of Toledo," the first major exhibition devoted to the paintings of the artist El Greco, is currently being held at the Toledo Museum of Art, Toledo, Ohio, and will continue until November 21.

The exhibition represents the largest number of paintings by him ever to be brought together. The 60 paintings include works of key importance from Europe and North America, some of which will be seen for the first time outside the locations where they have been housed for the past 400 years.

The exhibition presents a fresh interpretation of El Greco's work, based on recent scholarship which places this great master in the context of both his adopted city of Toledo and of Spain at the turn of the 17th

century. The exhibition is under the patronage of His Majesty Juan Carlos I, King of Spain, and President Ronald Reagan of the United States. "El Greco of Toledo" also marks the 50th anniversary of the sister-city relationship between Toledo, Ohio and Toledo, Spain. The exhibit also will be shown at the Museo del Prado, Madrid, Spain; the National Gallery of Fine Arts, Washington, D.C.; and the Dallas Museum of Fine Arts, Dallas, Texas.

The Toledo Museum of Art has special lectures and tours available. For more information contact El Greco Special Events, Toledo Museum of Art, Box 1013, Toledo, Ohio 43697.

Karen S. Edwards

elongation, the fingers should be short and stubby.

3. Astigmatism usually does not change greatly over time. However, El Greco's distortions progressed markedly as he aged.

4. One painting, "The Burial of the Count of Orgaz," has normally proportioned figures in the lower part of the canvas and distorted ones in the upper regions of the same painting. An ocular abnormality cannot explain this.

5. Astigmatism should not affect an artist's works. If the artist attempts to paint realistically, the object and its painted image should correspond. Otherwise, when the artist compares the two, a discrepancy will be noted. For example, if the artist sees in nature a point, but paints it as an elongated line, when the artist looks at the painted line it will appear to be even more elongated. This logic seems compelling, but in practice does not always work. Some astigmatic artists do distort along the line of their astigmatism.^{3,5}

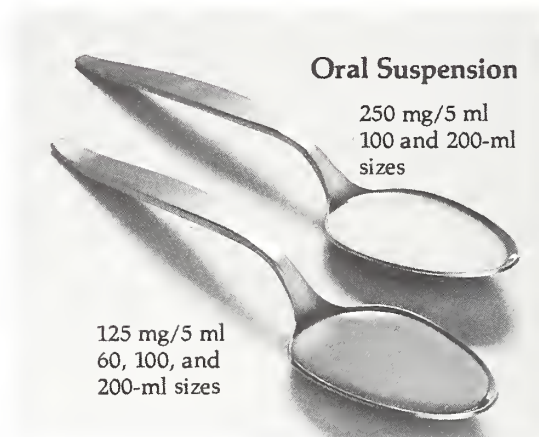
There is also one remote possibility. If El Greco had two dissimilar eyes,

one far-sighted and astigmatic and the other near-sighted, astigmatism could have had an effect. The far-sighted eye could have been used for seeing the object to be painted and the near-sighted eye could have been used to view the canvas, so that he would not be comparing the object and its painted image with the same eye. The arguments seem to favor the skeptics, but the answer awaits a prospective study of astigmatic artists.

CHANGES IN DETAILS AND COLORS

During El Greco's long artistic career he often painted the same theme several times. For example, there are several versions of "The Purification of the Temple" and "The Annunciation." This gives us the opportunity to compare early and late works. Comparison of the purification canvases reveals a loss of details with time and a change in colors from a wide range of hues in the early versions to late canvases in which reds and browns predominate, while violet, blue and green are minimized. Similar

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El Greco of Toledo

(continued)

changes in details and colors over time may be found in the paintings of other artists, including Titian, Constable, Rembrandt, Renoir,⁶ and Rouault.⁷

Changes in the ability to see details and in the perception of colors occur as we age. Difficulty with near vision (presbyopia) typically begins in the fifth decade of life. Changes in color vision occur with time, as the layers of the eye absorb an increasing amount of light, preventing it from reaching the receptors in the retina. Most of the light absorption occurs in the lens, which becomes yellow or brown tinged with time.⁸ The lens then acts like a filter, to block transmission of some light rays on their way to the retina. The yellow xanthophyll pigment in the macular region of the retina also can absorb light rays. These yellow filters in the lens and the macula primarily absorb violet, blue and some green rays (the shorter wave lengths), but permit red and brown

continuously added and are not shed, unlike the skin. Increased density of the lens with time is a physiologic fact. The age-related changes of the eye cause us all to see details less clearly and alter our color perception.

Examination of these two scenes of the Purification by El Greco shows these findings. More details are evident in the earlier work, which also has more violet, blue and green pigment, while the late work is more red and brown.

What other factors might account for these changes in details and colors? Centuries of accumulated varnish and dust can alter the appearance of paintings, but should not affect an artist's late works more than earlier ones, particularly if the paintings are carefully cleaned and restored. El Greco employed some assistants, including his son, which complicates the analysis somewhat. If an artist has not finished a painting, it may of course be sketchier than he intended. It also may be more brown if the artist used that color for underpainting and did not complete the top layers. An artist's style can evolve in the direction of less details and altered colors. El Greco consciously aimed to create a form of idealized beauty. If he felt that these changes in colors and details would further his goal, some effect could be found.

Scholars now view El Greco as primarily a painter of the Counter-Reformation. Toledo, Spain, was a seat

of that movement. The content of El Greco's paintings appealed to the ecclesiastical authorities of his era. His style, in all its vivid colors and dramatic depiction of the human body, remains appealing today.

James G. Ravin, M.D., Toledo, is an ophthalmologist and Chairman of the OSMA's Art and Culture Committee

El Greco consciously aimed to create a form of idealized beauty

rays (the longer wave lengths) to reach the retina.

Changes in color perception are not self-correcting, unlike astigmatism. That is, if an artist were to realize or be told that his color sense was changing, addition of more blue or green to his canvas would not improve the color balance. It would only darken the painting. Photographers are aware of this and often use yellow filters to eliminate some of the blueness of the sky and bring out clouds in contrast. A simple experiment also can verify this: Hold a yellow filter over one eye while drawing with a blue crayon. Placing more blue on the paper darkens the image rather than making it appear bluer. Unfortunately for all of us, the thickening of the human lens increases throughout life. Lens fibers are

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The Ohio Medical Malpractice Survey

Footprints of the Dragon

By Sidney F. Miller, M.D.



In January, 1981, a medical malpractice questionnaire was sent to the 2,005 members of the Ohio Chapter of the American College of Surgeons. Eight hundred and seven questionnaires were returned to the project chairman. This study was undertaken to evaluate the current malpractice problem in the State of Ohio as perceived by members of the Ohio Chapter. Additional data were obtained from Dr. Franklin Shively, Jr., who performed two previous malpractice surveys for the Ohio Chapter in 1969 and 1974.

This report summarizes the results of the current survey and additionally draws comparisons and contrasts between the current survey and the previous surveys. All percentages used in this report have been rounded off to the nearest whole percent.

1981 Survey

The 1981 survey consisted of 31 questions designed to assess the age and type of practice of the individual responders as well as their malpractice

experience and attitudes related to the malpractice situation in Ohio. 41% of the responders indicated that their specialty was general surgery. The mean age of the responders was 51 years, with ages ranging from 31 to 79 years of age. 48% were in solo practice, 21% were in partnerships, 21% were in group practice and 4% were hospital based.

Over 50% indicated they felt there was a malpractice problem . . . 94% carried malpractice insurance

Malpractice Experience

52% of the responders indicated they felt there was a medical malpractice problem in the State of Ohio. 94% carried malpractice insurance. 17% said that their

premiums are less than \$10,000 per year, while only 1% of the responders paid premiums higher than \$25,000 per year. 35% indicated that they had a 100% increase in their premiums in the last five years. Of the 5% of the responders who were bare (did not carry malpractice insurance), 85% had been without malpractice insurance for greater than two years. 52% had been sued in the previous five years and of those, 68% had either one or two suits. Only 23% of the suits actually went to court. Settlement was made by the insurance companies, out of court, in 73% of these suits. 8% of the suits were settled through pretrial arbitration and only 18% were settled as a result of court trial. 8% of the responders indicated that they had difficulty in obtaining malpractice insurance. 64% said that either old malpractice carriers had reentered the marketplace since the last survey, or new carriers had become available. 8% of those surveyed felt that second opinion programs would have a significant effect in reducing

malpractice claims, and 55% participated in second opinion programs.

Malpractice Attitudes

A number of questions about attitudes regarding the malpractice problem were included in the questionnaire. 63% of the responders felt that insurance companies were too ready to settle suits regardless of the validity of the suit. 80% felt that efforts should be made to jointly consider liability problems with local and national Bar Associations and insurance companies. 80% felt that mandatory presentation of malpractice claims to medicolegal investigating committees should be undertaken. 86% felt that plaintiff bonds should be mandatory to pay court costs for unsuccessful suits. 81% of the responders felt that the continuancy fee and the use of *res ipsa loquitur* should be banned from malpractice cases. 90% of the responders felt that the questions of Statutes of Limitation should be invoked prior to the trial of negligence suits. 85% of the responders favored some type of arbitration but less than half (48%) indicated that there was an active medical malpractice arbitration program in their area. 53% of the responders felt that predefined compensation for medical malpractice, similar to Workmen's Compensation, would be beneficial and 59% felt that some type of "no fault" insurance, similar to Flight Travel Insurance, was indicated. Only 45% of the responders indicated their hospital had a risk management program.

Finally, second opinion programs were addressed in this year's survey. Second opinion programs are being touted as the final answer to the medical malpractice problem. However, only 8% of the responders indicated that they felt that these second opinion programs for elective surgery would have a significant effect in reducing malpractice claims. Additionally, 44% of the responders

indicated that they did not participate in second opinion programs. Suggestions also have been made that an active hospital risk management program would be the final solution to the malpractice problem. When queried about risk management programs, only 45% of the responders indicated that there was such a program in their institution.

Comparison With Previous Surveys

Although the 1981 survey was not identical to past surveys, a large part of it was designed to duplicate answers to questions obtained in the 1969 and 1974 surveys. Differences were appreciated over the years in both the nature of the responders, indicating possible changes in the nature of the Chapter itself, as well as differences in both attitudes and the malpractice problem.

In 1969, 52% of the responders indicated that they were general surgeons. This year, only 41% were general surgeons which was a figure fairly similar to the 1974 figure (44%). The difference between the 1969 figures and those for 1974 and 1981 were significantly different. OB-GYN

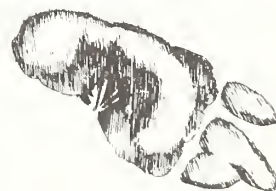
In 1969, 31% indicated they had been sued, in 1974, 34% had been sued. This year (1981), 52% had been sued.

compromised 10% of the responders in 1969 and 1974, but only 7% of the responders in 1981. However, there were twice as many vascular surgeons in 1981 as in 1974. There was also an increase in the percentage of urologists and otolaryngologists, while the percentage of plastic surgeons almost doubled.

One of the most marked shifts was the change in age distribution of the responders. In 1969 only 1% of the responders were in their thirties, while this year 16% were in this age group. In 1969, 33% of the responders were less than 50 years of age while this year almost half (48%) were under 50 years of age.

It is interesting to note that although there is less heard about the malpractice problem today, a higher percentage of the responders indicated that they had been sued than in any of the previous surveys. In 1969, only 31% of the responders indicated that they had been sued in the previous five years. In 1974, 34% had been sued, while this year 52% indicated that they had been sued in the previous five years. As in previous years, only about a quarter of the suits actually go to court. Out-of-court settlements were effected by the insurance company in an alarmingly stable percentage over the past 12 years (1969 - 72%, 1974 - 70%, 1981 - 71%).

As in the 1969 survey, 63% of the responders indicated that the insurance companies were too ready to settle claims that were not warranted. 80% of the responders again felt that meetings with Bar Associations and insurance companies would be beneficial but this percentage is significantly lower than that of the 1969 study. Again, the members of the Chapter felt quite strongly that a plaintiff's bond for court costs of unwarranted suits was indicated. In 1969 only 5% of the responders indicated that they had difficulty obtaining malpractice insurance, while in 1981, 8% of the responders had had



Footprints of the Dragon

(continued)

difficulty in obtaining malpractice insurance.

DISCUSSION

The percentage of responders indicating their specialties as general surgery was relatively stable from the 1974 survey, however, there was a marked decline in the percentage of general surgeons since 1969, when over half indicated that their specialty was general surgery. There is a significant change in the age composition of the responders in this year's survey compared to previous surveys with almost half (48%) of this year's responders being less than 50 years of age. Whether this represents a true change in the age composition of the Chapter, fewer surgeons over 50 years remaining in practice, or fewer responses by the older members of the Chapter, cannot be determined.

Although there has been a problem in the past with escalating premiums, it would appear from this year's survey that there has been some stabilization in the premiums. In both 1969 and 1974, a high percentage of responders indicated that there had been a greater than 100% increase in their premiums. In this year's survey, only about a quarter of the responders indicated that they have experienced this type of increase. A majority of the responders indicated that their annual premium was less than \$10,000 per year.



Although there is less publicity about the malpractice problems in the State of Ohio today than in the past, it is interesting to note that a significantly higher percentage of responders indicated they had been sued in the previous five years than in either of the previous surveys. In 1969, 31% of the responders indicated that they had been sued while in 1974, 34%

continued on page 758



The Dragon Tamers

In March, the *Ohio State Medical Journal* ran an article by OSMA's Communications Director, Rebecca J. Doll, on "Malpractice. How Ohio physicians are taming the dragon." The article outlined how the Physicians Insurance Company of Ohio (PICO) is taking steps to prepare for any malpractice crisis that may formulate over the next few years. Some of the steps they have been (and are) taking are: adequately capitalizing the company; charging realistic premium rates; involving physicians in the claim process; and using a Risk Management Committee that attempts to determine how claims may have been prevented.

PICO's Board Chairman, William H. Wells, M.D., was quoted as saying: "When the crisis hits again, and I believe it will, I'm confident we'll be prepared for it. We know what has to be done to protect Ohio doctors, and we're doing it."

An interesting sidelight to the survey response which indicated "Members of the Ohio Chapter again indicated their willingness to meet with . . . Bar Associations to try and

improve the malpractice problem" is the 20-minute audiovisual presentation developed jointly by the Cincinnati Academy of Medicine and the Cincinnati Bar Association. The film entitled, "Anatomy of a Lawsuit," and described in the September 13 OSMAgram, promotes a sense of cooperation and understanding of mutual problems between the two professions. Told from the client/patient point of view, the show traces the procedures in a personal injury case and highlights points of conflict between doctors and lawyers. Three physicians, three lawyers and a judge — all from Cincinnati — offer their opinions in a point/counterpoint that covers depositions, written reports and fees. The show draws no conclusion, but provides a good launching point for conversation about an important topic. The presentation is available for showing at your county society meeting, and further information may be obtained by contacting Leslie Laine, Cincinnati Academy of Medicine, 513-421-7010.

—Karen S. Edwards

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The Physician's Sleep Glossary

Some common sleep laboratory terms

poly·som·no·graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tone (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la·ten·cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af·ter sleep on·set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to·tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.¹

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.²

re·bound in·som·nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.³

Efficacy objectively demonstrated in the sleep laboratory—the most valid environment for measuring hypnotic efficacy.

In numerous sleep laboratory investigations patients fell asleep sooner, slept longer and woke up less during the night³⁻¹² with

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Compared with temazepam and other hypnotics, onset of sleep is more rapid⁴ with

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Fewer middle-of-the-night awakenings⁴ with

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More total sleep time on nights 12 to 14 of therapy⁴ and continued efficacy for up to 28 nights⁵ with

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Rebound insomnia is avoided upon discontinuation^{3,4,7} of

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Low incidence of morning "hang-over"¹⁴ with

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The efficacy of Dalmane has been studied in over 200 clinical trials with more than 10,000 patients.³⁻¹⁵ During long-term therapy, which is rarely required, periodic blood, kidney and liver function tests should be performed. Contraindicated in patients who are pregnant or hypersensitive to flurazepam.

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flurazepam HCl/Roche
15-mg/30-mg capsules

Dalmane® 
(flurazepam HCl/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, light-headedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.



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Footprints of the Dragon

(continued)

had been sued. This year, 52% had been sued. This increase was statistically significant.

Again, it is quite apparent that very few suits go to court and that insurance companies appear too ready to settle out of court. In 1969, only 21% of the suits went to court; 1974, 26% went to court; and 1981, 23% went to court. In 1969, 72% of the cases were settled out of court; 1974, 70% were settled out of court; and again in 1981, 72% were settled out of court. In both the 1969 and 1981 surveys, almost two thirds of the members of the Chapter felt that insurance companies and lawyers were too ready to settle suits out of court, regardless of the validity of the suit.

SUMMARY

The following summary points are suggested by the 1981 survey and comparisons with the previous surveys:

1. The percentage of responders indicating that their specialty was general surgery essentially is unchanged since 1974, however, there has been a significant change since 1969. The age of the responders is significantly lower than in the previous surveys with almost half of the responders now being under 50 years of age.

2. Half the responders felt that there continued to be a medical malpractice problem and the overwhelming majority carried malpractice insurance. Although there have been problems in the past with escalating premiums, over 70% of the responders indicated that their premiums were less than \$10,000, and a much lower percentage indicated that there had been significant increases in their premiums. Few had difficulty obtaining malpractice insurance. Two thirds indicated that either old malpractice carriers have reentered their markets or new carriers have become available in the last several years.

3. Although there is less publicity regarding the malpractice problem, a significantly higher percentage of responders had been sued than in either of the previous surveys. Almost 70% of the responders sued, however, had only been sued once or twice with a minority having been sued five or more times. Very few suits go to court and insurance companies appear too ready to settle suits. The majority of suits are settled out of court. These attitudes and findings have been consistent throughout the last 12 years.

4. Members of the Ohio Chapter again indicated their willingness to meet with insurance companies and Bar Associations to try and improve the malpractice problem. They continue to be willing to submit to local medicolegal investigating committees and feel quite strongly as they did in 1969 that a plaintiff bond should be posted to pay court costs when suits are denied. 90% of the responders felt that the Statute of Limitations should be allowed to be introduced as evidence in a malpractice suit. 85% of the responders indicated their willingness to participate in some type of arbitration program, however, less than half indicated that there was any type of active malpractice arbitration in their areas. Slightly over half felt that some type of predefined compensation similar to Workmen's Compensation or no fault insurance was needed and would be helpful.



Sidney F. Miller, M.D., Dayton, served as project chairman, Ohio Chapter of the American College of Surgeons, during this study.



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Each prolonged action tablet contains: Phenylephrine Hydrochloride 25 mg
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Tablets

DESCRIPTION

Each prolonged action tablet contains:

Phenylephrine Hydrochloride	25 mg
Phenylpropanolamine Hydrochloride	50 mg
Chlorpheniramine Maleate	8 mg
Hyoscyamine Sulfate	0.19 mg
Atropine Sulfate	0.04 mg
Scopolamine Hydrobromide	0.01 mg

Ru-Tuss Tablets act continuously for 10 to 12 hours.

Ru-Tuss Tablets are an oral antihistaminic, nasal decongestant and anti-secretory preparation.

INDICATIONS AND USAGE Ru-Tuss Tablets provide relief of the symptoms resulting from irritation of sinus, nasal and upper respiratory tract tissues. Phenylephrine and phenylpropanolamine combine to exert a vasoconstrictive and decongestive action while chlorpheniramine maleate decreases the symptoms of watering eyes, post nasal drip and sneezing which may be associated with an allergic-like response. The belladonna alkaloids, hyoscyamine, atropine and scopolamine further augment the anti-secretory activity of Ru-Tuss Tablets.

CONTRAINDICATIONS Hypersensitivity to antihistamines or sympathomimetics. Ru-Tuss Tablets are contraindicated in children under 12 years of age and in patients with glaucoma, bronchial asthma and women who are pregnant. Concomitant use of MAO inhibitors is contraindicated.

WARNINGS Ru-Tuss Tablets may cause drowsiness. Patients should be warned of the possible additive effects caused by taking antihistamines with alcohol, hypnotics, sedatives or tranquilizers.

PRECAUTIONS Ru-Tuss Tablets contain belladonna alkaloids, and must be administered with care to those patients with glaucoma, or urinary bladder neck obstruction. Caution should be exercised when Ru-Tuss Tablets are given to patients with hypertension, cardiac or peripheral vascular disease or hyperthyroidism. Patients should avoid driving a motor vehicle or operating dangerous machinery (See Warnings).

OVERDOSAGE Since the action of sustained release products may continue for as long as 12 hours, treatment of overdoses directed at reversing the effects of the drug and supporting the patient should be maintained for at least that length of time. Saline cathartics are useful for hastening evacuation of unreleased medication. In children and infants, antihistamine overdosage may produce convulsions and death.

ADVERSE REACTIONS Hypersensitivity reactions such as rash, urticaria, leukopenia, agranulocytosis, and thrombocytopenia may occur. Other adverse reactions to Ru-Tuss Tablets may be drowsiness, lassitude, giddiness, dryness of the mucous membranes, tightness of the chest, thickening of bronchial secretions, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, dizziness and insomnia. Large overdoses may cause tachypnea, delirium, fever, stupor, coma and respiratory failure.

DOSAGE AND ADMINISTRATION Adults and children over 12 years of age, one tablet morning and evening. Not recommended for children under 12 years of age. Tablets are to be swallowed whole.

HOW SUPPLIED:

Bottles of 100 Tablets

Bottles of 500 Tablets

Federal law prohibits dispensing without prescription.

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RU-TUSS®

Expectorant

DESCRIPTION

Each fluid ounce of Ru-Tuss Expectorant contains:

Codeine Phosphate	65.8 m
(WARNING: MAY BE HABIT FORMING)	
Phenylephrine Hydrochloride	30 m
Phenylpropanolamine Hydrochloride	20 m
Pheniramine Maleate	20 m
Pyrimamine Maleate	20 m
Ammonium Chloride	200 m
Alcohol	5

Ru-Tuss Expectorant is an oral antitussive, antihistaminic, nasal decongestant and expectorant preparation.

INDICATIONS AND USAGE Ru-Tuss Expectorant is indicated for symptomatic relief of upper respiratory congestion associated with pharyngitis, tracheitis, bronchitis, and allergic rhinitis. Also, for the temporary relief of symptoms associated with hay fever, allergies, nasal congestion and cough due to the common cold.

CONTRAINDICATIONS Hypersensitivity to antihistamines. Concomitant use of an antihypertensive or antidepressant drug containing a monoamine oxidase inhibitor is contraindicated.

Ru-Tuss Expectorant is contraindicated in patients with glaucoma, bronchial asthma and in women who are pregnant.

WARNINGS Ru-Tuss Expectorant contains codeine phosphate, therefore, the patient should be warned of the potential that this drug may be habit forming. Ru-Tuss Expectorant may cause drowsiness. Patients should be warned of the possible additive effect caused by taking antihistamines with alcohol, hypnotics, sedatives and tranquilizers.

PRECAUTIONS Patients taking Ru-Tuss Expectorant should avoid driving a motor vehicle or operating dangerous machinery (See Warnings). Caution should be taken with patients having hypertension, diabetes, hyperthyroidism and cardiovascular disease.

Caution should also be used in patients with pulmonary, hepatic or renal insufficiency.

ADVERSE REACTIONS Ru-Tuss Expectorant may cause drowsiness, lassitude, giddiness, dryness of mucous membranes, tightness of the chest, thickening of bronchial secretion, urinary frequency and dysuria, palpitation, tachycardia, hypotension/hypertension, faintness, dizziness, tinnitus, headache, incoordination, visual disturbances, mydriasis, xerostomia, blurred vision, anorexia, nausea, vomiting, diarrhea, constipation, epigastric distress, hyperirritability, nervousness, and insomnia. Overdoses may cause restlessness, excitation, delirium, tremors, euphoria, metabolic acidosis, stupor, tachycardia and even convulsions.

DOSAGE AND ADMINISTRATION Adults: 1 or 2 teaspoonfuls, orally, every 4 hours, not to exceed 10 teaspoonfuls in any 24-hour period.

Children 6 to 12 years of age: 1/2 the adult dose, not to exceed 6 teaspoonfuls in any 24-hour period. Children 2 to 6 years of age: 1/2 teaspoonful every 4 hours, not to exceed 3 teaspoonfuls in any 24-hour period. Children under 2 years of age: Use only as directed by a physician.

HOW SUPPLIED: (16 fl. oz.)

Pint Bottles

Federal law prohibits dispensing without prescription.

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Graduate Medical Education. Who is Responsible?

*By Stephen Peterson, Ph.D. and
Alvin E. Rodin, M.D.*

As of July, 1982, all residency programs were asked to comply with the new Essentials of Accredited Residencies in Graduate Medical Education, recently revised by the Accreditation Council on Graduate Medical Education (ACGME). The purpose of this article is to review the new general requirements and to describe how they differ from those which had been in effect.

Responsibility of Institutions

The revised general requirements require hospitals to establish institutional responsibility for residency training, a provision not included in the old requirements (see Table One). Whether the sole or cosponsor of a residency program, hospitals are required to provide documentary evidence of a commitment to graduate medical education (GME).

When the resources of two or more hospitals are utilized for the conduct of a single residency program, the revised general requirements call for the establishment of an

interinstitutional agreement (see Table One).

Under the outdated essentials, programs provided training in a collaborating hospital in disciplines deficient or nonexistent in the parent hospital, provided (1) departmental staff of the parent hospital remained primarily responsible, (2) the length of time did not exceed more than a third of the training period, and (3) that training in the collaborating hospital was of GME caliber. Under the revised general requirements, new emphasis has been placed upon establishing formal interinstitutional agreement related to the expected financial, educational, and administrative contribution that each hospital will make to the residency program.

Types of Programs

Under the old system, three types of residency programs were accredited by the ACGME: (1) Flexible Programs, first-year programs sponsored by two or more approved programs; (2) Categorical Programs, programs where the first year of training was limited to

the specialty field of the sponsoring residency; and (3) Categorical* Programs, programs where the first year of training included experiences outside the sponsoring field. In the revised general requirements, the number of types of programs has been reduced from three to two.

Eligibility and Selection of Residents

Eligibility for entrance of residents into ACGME approved programs has been changed in the revised general requirements to establish an additional category, restricted eligibility (see Table One). Unrestricted eligibility will continue to be granted as before to:

1. Graduates of Liaison Committee on Medical Education (LCME) approved institutions (domestic and Canadian medical schools).
2. Graduates of non-LCME approved programs who have Educational Commission for Foreign Medical Graduates certification.
3. Graduates of non-LCME approved programs who are fully licensed to

TABLE ONE
NEW REQUIREMENTS OF THE REVISED ESSENTIALS

Area	Outdated General Essentials	Revised General Essentials
Responsibilities of Institutions		
commitment	not addressed	must have documentary evidence of reasons for sponsoring GME, and the process by which educational resources are distributed
systems	not addressed	must have systems for appointment of teaching staff; selection of residents; apportionment of residency positions among programs; supervision of residents; evaluation, advancement, and dismissal of residents; and assurance of due process
program evaluation	not addressed	must be periodic analysis of each program's goals and objectives, instructional plans, overall effectiveness, and utilization of resources
interinstitutional agreements	not addressed	must exist and include designation of program director and scope of authority, identification of teaching staff, and expected educational and financial contribution of each hospital to program
types of programs	establishes three types of programs — Categorical, Categorical* and Flexible	establishes two types of programs — Categorical and Transitional (the latter must have an educational committee, qualified director, selected educational settings, association with more senior residents and not be deleterious to Categorical programs)
eligibility	describes five criteria for eligibility, one of which must be met by entrants to ACGME-approved programs	establishes two categories of eligibility — restricted and unrestricted; five criteria for the unrestricted category remain the same; a restricted category with four criteria has been added for the FMGs who will return to their country of origin after training in an ACGME-approved program
National Residency Matching Program	not addressed	participation is expected by all programs except selected federal uniform services
hospital-resident	required	required and must include resident responsibilities, benefits, terms of residency, practice privileges outside program, usual call schedule, and guarantee of due process
due process	must be mechanism for redress of grievances	must have a policy, it must be approved by the governing board, it must be made known, and it must be adhered to by all programs in the institution
annual evaluation and reappointment	must have clearly stated basis for annual reappointment	must be basis for annual evaluation and advancement including knowledge, skills, and professional growth
JCAH accreditation	not required	required
hospital facilities	must be adequately constructed and planned	must have sufficient space for instruction, patient care, medical records, pathology, and radiology
library	must have access	must have a library with standard reference texts and current journals
psychological support systems for residents	not required	required
cost containment	not addressed	residents should apply cost containment measures
personal program of self study	not addressed	each resident is expected to develop a program of self study

Graduate Medical Education. Who is Responsible?

(continued)

practice in the United States.

4. United States nationals who are graduates of foreign medical schools and have a full license to practice medicine in the United States.

5. Fifth pathway applicants (United States nationals who attended a foreign medical school and possess a temporary license to practice).

In the case of graduates from institutions in the United States accredited by the American Osteopathic Association (AOA), the general requirements also have been changed. In the past, eligibility was restricted to residents training in those specialties for which corresponding AOA approved specialty boards had established conditions under which the resident would be acceptable for certification. Under the revised requirements, however, any graduate of an AOA approved institution will be eligible to enter an ACGME accredited program, regardless of AOA specialty certification requirements. A second category termed restricted eligibility, has been established for the foreign medical school graduate who (1) is licensed in a foreign country; (2) has passed an exam in written and spoken English; (3) has made a commitment to return to their country of origin; and (4) has had their credentials validated by an organization acceptable to the ACGME.

All institutions with the exception of selected federal uniformed services are expected to participate in the National Residency Matching Program, a new provision not addressed in the old requirements. The enrollment of noneligibles in any program may jeopardize its accreditation, also a new requirement not officially mandated in the past.

Other Prescriptive Changes

The revised general requirements appear to be much more stringent in the area of hospitals' responsibilities to

residents (see Table One). Future employment agreements must include specific provisions not required previously, such as terms of the residency, call schedules, moonlighting privileges, benefits, residents' responsibilities, and a guarantee of due process. Under the past general requirements, hospitals are required to have a mechanism for the "redress of grievances," but in the revised version, hospitals must have a due process policy which has been approved by the governing board. This

Residents must now apply cost containment measures in the provision of patient care . . .

policy must be made known to attendings and staff, and must be adhered to by all programs in the institution. Hospitals now are required to evaluate residents' performances annually, also a new requirement. Annual performance evaluation and advancement must be based on residents' knowledge, skills and professional growth.

The revised general requirements are more descriptive in the area of hospital facilities and resources. Hospitals are required to have sufficient space for instruction, patient care, medical records, pathology, radiology, and a library. The library must contain standard reference texts and current journals, a provision not included in the past. Hospitals for the first time are required to provide residents with psychological support

systems and to be accredited by the Joint Commission on Accreditation of Hospitals (JCAH).

The revised general requirements address educational responsibilities of residents in two areas not included in the old requirements. Specifically mentioned is the requirement that residents apply cost containment measures in the provision of patient care and that each develop a program of "self study."

Less Prescriptive Changes

The revised general requirements appear to be much less prescriptive in areas relating to curriculum (see Table Two). For example, specifically mandated assignment of residents to the emergency service, outpatient department, and operating room has not been included; required participation in research, and teaching by residents has been dropped; and the provision to provide residents with training in applied basic sciences has been discontinued. Methods of instruction also are less stringently prescribed. Specific techniques such as bedside teaching, departmental conferences, and seminars, all mandated in the past general requirements, have not been addressed in the revised version. The requirement for hospitals to provide special support to Foreign Medical Graduates (FMGs) such as orientation programs, educational remediation, programs in cultural education, and experiences related to the FMG's country of origin also have been discontinued.

Unchanged Areas

As in the past, however, the revised version places high importance on the involvement of residents in the hospital governing structure (see Table Three). Residents still are expected to participate in hospital programs and

continued on page 769



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Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in external and internal hemorrhoids, proctitis, papillitis, cryptitis, and fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol[®] Suppositories or Ointment.

CONTRAINDICATIONS

Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations.

WARNINGS

The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time.

PRECAUTIONS

General

Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Anusol-HC is not for ophthalmic use.

Pregnancy

See "WARNINGS."

Pediatric Use

Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

DOSEAGE AND ADMINISTRATION

Anusol-HC Suppositories—Adults: Remove foil wrapper and insert suppository into the anus. Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides. Then maintain comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

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* Meeting of Am Soc Colon/Rectal Surgeons, May 1980.

** Based on total prescriptions filled for hemorrhoidal preparations during the first three quarters of 1981. The National Prescription Audit, IMS America Ltd, Sept 1981.

† 1981 data from leading marketing research organization.



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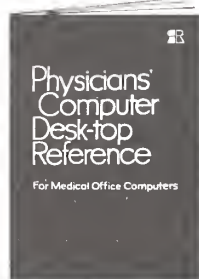
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Graduate Medical Education.
Who is responsible?

(continued)

committees. Supervision of residents by the teaching staff and the need to maintain a personal record on each resident also are emphasized in the new requirements. In many areas, provisions specifically addressed in the old requirements will continue to be important in accreditation evaluation, although not specifically mandated.

Discussion

As mechanisms are implemented for institutional decision making under the new general requirements, program directors will be able to operate less autonomously than in the past and will be more responsible to their colleagues. It seems probable that hospitals will develop organizational structures for the administration of education similar to the university. Directors of medical education or vice-presidents for education in community hospitals may become more instrumental in the educational conduct of residency programs as institutional responsibility develops.

It seems probable that hospitals will develop organizational structures to administer education

Realistically, hospitals cannot be expected to develop institutional responsibility overnight and a "grace" period will be required for complete implementation and full compliance with the new essentials.

TABLE TWO
 AREAS ADDRESSED IN THE CURRENT ESSENTIALS BUT DROPPED IN THE REVISED ESSENTIALS

Area	Outdated General Essentials
participation in research	encouraged
part-time programs	highly desirable
methods of instruction	at bedside, teaching rounds, departmental conferences and seminars
journal club	suggested
outpatient department	residents should have definitive assignment
emergency service	assignment suggested
operating room	assignment suggested
FMGs	should be given orientation, deficits should be corrected, should provide programs to help understand culture, should include experiences relative to FMG's country of origin
basic science training	must provide training to residents in applied basic sciences
annual report to Council on Medical Education	required

GME in the United States has developed as both a medical school and community hospital responsibility. In community hospitals, it is typically thought of as a departmental activity, secondary to its primary mission (patient care). Although historically not the case, GME is viewed today as necessary training for the clinical development of all physicians. For GME to approach the outstanding level of excellence uniformly characteristic of undergraduate medical education today, it is assumed that

hospitals (institutions) must accept corporate responsibility for the conduct of it, similar to the manner in which medical schools have assumed corporate responsibility for undergraduate medical education.

Stephen Peterson, Ph.D., Xenia, is the Head of Residency Education at Wright State University. A.E. Rodin, M.D., Dayton, is Chairman, Department of Postgraduate Medicine, Wright State University.

TABLE THREE
 UNCHANGED AREAS IN THE REVISED GENERAL ESSENTIALS

Area	General Essentials	Revised General Essentials
hospital policies, programs and committees	residents should help to develop hospital policies	residents should participate in programs and committees
supervision of residents by teaching staff	all phases of resident's work must be closely and continuously supervised	all residents must be supervised
personal records	should maintain records for each resident	must maintain personal record on each resident

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MEDICAL ADVANCES



Ophthalmology

The eyes have it . . .

By Gina DiBlasio Cummins

Editor's Note: This article begins a new department for the Ohio State Medical Journal. "Medical Advances" will take a look at what's new in the different specialty fields, providing updated information on diagnostic techniques, treatments and perhaps a new understanding of the disease, itself.

The purpose of the department is to bring to light new and recent developments, so that the practicing physician will have a greater understanding of the direction medicine is headed in areas in which he or she may not be totally familiar.



Gary L. Rogers, M.D., Columbus.

If it's been a long time since you've tested your Eye-Q in ophthalmology, you may be surprised at the many technological advances that have occurred in the past several years.

Besides the development of new procedures and treatment methods, improved instrumentation has enabled the repair and restoration of vision more frequently than in the past. In order to bring you up to date on what's new in this changing field of medicine, Gary L. Rogers, M.D., a Columbus pediatric ophthalmologist and Chief of Ophthalmology at Children's Hospital, focuses on several of the following highlights that have recently occurred in ophthalmology.

- **Development of the argon laser**

Dr. Rogers explains that the argon laser is one of the newest and most valuable devices that can be used for

which is quick and painless, produces a small beam of intense heat and energy which causes burns of varying degrees in the tissues of the eye. This procedure frequently is used to treat eye hemorrhaging due to diabetes.

"This hemorrhaging, called diabetic retinopathy, occurs when the blood vessels in the retina of the eye swell and microaneurysms swell and rupture." Following several applications of the argon laser, the hemorrhaging blood vessels in the eye begin to clot and the problem is alleviated. The argon laser also is being used in surgery to treat detached retinas. The hole or tear is repaired much like spot welding with a very high success rate.

- **Correcting refractive errors**

The ability to correct refractive errors also has significantly improved. Dr.

The laser procedure, both quick and painless, produces a beam of intense heat and energy which causes burns of varying degrees in eye tissue.

diagnosing and treating many diseases of the eye. In addition, it is being used increasingly as a surgical tool in the operating room. The laser procedure,

Rogers explains that refractive keratoplasty is one such procedure which involves transplanting a healthy donor cornea and sewing it to the

continued on page 777

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propranolol hydrochloride	Hydrochlorothiazide	25 mg
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and hydrochlorothiazide	Propranolol hydrochloride (INDERAL®)	25 mg
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WARNING: This fixed combination drug is not indicated for initial therapy of hypertension. Hypertension requires therapy titrated to the individual patient. If the fixed combination represents the dosage so determined, its use may be more convenient in patient management. The treatment of hypertension is not static, but must be reevaluated as conditions in each patient warrant.

INDICATION: **INDERIDE** is indicated in the management of hypertension. (See boxed warning.)

CONTRAINDICATIONS: **Propranolol hydrochloride (INDERAL®):** Propranolol hydrochloride is contraindicated in: 1) bronchial asthma, 2) allergic rhinitis during the pollen season; 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless the failure is secondary to a tachyarrhythmia treatable with propranolol, 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs.

Hydrochlorothiazide: Hydrochlorothiazide is contraindicated in patients with anuria or hypersensitivity to this or other sulfonamide-derived drugs.

WARNINGS: **Propranolol hydrochloride (INDERAL®):** **CARDIAC FAILURE:** Sympathetic stimulation is a vital component supporting circulatory function in congestive heart failure, and inhibition with beta blockade always carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. Propranolol acts selectively without abolishing the inotropic action of digitalis on the heart muscle (i.e., that of supporting the strength of myocardial contractions). In patients already receiving digitalis, the positive inotropic action of digitalis may be reduced by propranolol's negative inotropic effect. The effects of propranolol and digitalis are additive in depressing AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, continued depression of the myocardium over a period of time can, in some cases, lead to cardiac failure. In rare instances, this has been observed during propranolol therapy. Therefore, at the first sign or symptom of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and the response observed closely a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol therapy should be immediately withdrawn, b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and the patient closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of propranolol therapy. Therefore, when discontinuance of propranolol is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when propranolol is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If propranolol therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute propranolol therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long-term use have not been adequately appraised. Special consideration should be given to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Therefore, abrupt withdrawal of propranolol may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. This is another reason for withdrawing propranolol slowly. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta blockade impairs the ability of the heart to respond to reflex stimuli. For this reason, with the exception of pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery, at which time all chemical and physiologic effects are gone according to available evidence. However, in case of emergency surgery, since propranolol is a competitive inhibitor of beta-receptor agonists, its effects can be reversed by administration of such agents, e.g., isoproterenol or levaterenol. However, such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has also been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), propranolol should be administered with caution since it may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOLYCEMIA: Because of its beta-adrenergic blocking activity, propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia. This is especially important to keep in mind in patients with labile diabetes. Hypoglycemic attacks may be accompanied by a precipitous elevation of blood pressure.

Hydrochlorothiazide: Thiazides should be used with caution in severe renal disease. In patients with renal disease, thiazides may precipitate azotemia. In patients with impaired renal function, cumulative effects of the drug may develop.

Thiazides should also be used with caution in patients with impaired hepatic function or progressive liver disease, since minor alterations of fluid and electrolyte balance may precipitate hepatic coma.

Thiazides may add to or potentiate the action of other antihypertensive drugs. Potentiation occurs with ganglionic or peripheral adrenergic blocking drugs.

Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. The possibility of exacerbation or activation of systemic lupus erythematosus has been reported.

USE IN PREGNANCY: **Propranolol hydrochloride (INDERAL®):** The safe use of propranolol in human pregnancy has not been established. Use of any drug in pregnancy or women of childbearing potential requires that the possible risk to mother and/or fetus be weighed against the expected therapeutic benefit. Embryotoxic effects have been seen in

animal studies at doses about 10 times the maximum recommended human dose.

Hydrochlorothiazide: Thiazides cross the placental barrier and appear in cord blood. The use of thiazides in pregnant women requires that the anticipated benefit be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult.

Nursing Mothers: Thiazides appear in breast milk. If the use of the drug is deemed essential, the patient should stop nursing.

PRECAUTIONS: **Propranolol hydrochloride (INDERAL®):** Patients receiving catecholamine-depleting drugs such as reserpine should be closely observed if propranolol is administered. The added catecholamine blocking action of this drug may then produce an excessive reduction of the resting sympathetic nervous activity. Occasionally, the pharmacologic activity of propranolol may produce hypotension and/or marked bradycardia resulting in vertigo, syncope attacks, or orthostatic hypotension.

As with any new drug given over prolonged periods, laboratory parameters should be observed at regular intervals. The drug should be used with caution in patients with impaired renal or hepatic function.

Hydrochlorothiazide: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals.

All patients receiving thiazide therapy should be observed for clinical signs of fluid or electrolyte imbalance, namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as diuretics may also influence serum electrolytes. Warning signs, irrespective of cause are: dryness of mouth, thirst, weakness, lethargy, drowsiness, restlessness, muscle pains or cramps, muscular fatigue, hypotension, oliguria, tachycardia, and gastrointestinal disturbances such as nausea and vomiting.

Hypokalemia may develop, especially with brisk diuresis, when severe cirrhosis is present or during concomitant use of corticosteroids or ACTH.

Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Hypokalemia can sensitize or exaggerate the response of the heart to the toxic effects of digitalis (e.g., increased ventricular irritability). Hypokalemia may be avoided or treated by use of potassium supplements such as foods with a high potassium content.

Any chloride deficit is generally mild, and usually does not require specific treatment except under extraordinary circumstances (as in liver or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather; appropriate therapy is water restriction, rather than administration of salt, except in rare instances when the hyponatremia is life-threatening. In actual salt depletion, appropriate replacement is the therapy of choice.

Hyperuricemia may occur or frank gout may be precipitated in certain patients receiving thiazide therapy.

Insulin requirements in diabetic patients may be increased, decreased, or unchanged. Diabetes mellitus which has been latent may become manifest during thiazide administration.

Thiazide drugs may increase the responsiveness to tubocurarine.

The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Thiazides may decrease arterial responsiveness to norepinephrine. This diminution is not sufficient to preclude effectiveness of the pressor agent for therapeutic use.

If progressive renal impairment becomes evident, consider withholding or discontinuing diuretic therapy.

Thiazides may decrease serum PBI levels without signs of thyroid disturbance.

Calcium excretion is decreased by thiazides. Pathologic changes in the parathyroid gland with hypercalcemia and hypophosphatemia have been observed in a few patients on prolonged thiazide therapy. The common complications of hyperparathyroidism such as renal lithiasis, bone resorption, and peptic ulceration, have not been seen. Thiazides should be discontinued before carrying out tests for parathyroid function.

ADVERSE REACTIONS: **Propranolol hydrochloride (INDERAL®):** **Cardiovascular:** bradycardia; congestive heart failure, intensification of AV block, hypotension; paresthesia of hands; arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura.

Central Nervous System: lightheadedness; mental depression manifested by insomnia, lassitude, weakness, fatigue; reversible mental depression progressing to cataplexy; visual disturbances; hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics.

Gastrointestinal: nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis.

Allergic: pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress.

Respiratory: bronchospasm.

Hematologic: agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura.

Miscellaneous: reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta blocker (practolol) have not been conclusively associated with propranolol.

Clinical Laboratory Test Findings: Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

Hydrochlorothiazide: **Gastrointestinal:** anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis, sialadenitis.

Central Nervous System: dizziness, vertigo, paresthesias, headache, xanthopsia.

Hematologic: leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia.

Cardiovascular: orthostatic hypotension (may be aggravated by alcohol, barbiturates, or narcotics).

Hypersensitivity: purpura, photosensitivity, rash, urticaria, necrotizing angitis (vasculitis, cutaneous vasculitis), fever, respiratory distress including pneumonitis, anaphylactic reactions.

Other: hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, transient blurred vision.

Whenever adverse reactions are moderate or severe, thiazide dosage should be reduced or therapy withdrawn.

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Ophthalmology — The eyes have it (continued)

recipient's eye. "This living contact lens can restore vision remarkably well and the transplant procedure is constantly being perfected."

Radial keratotomy is another surgical procedure being used to improve the vision of near-sighted people who cannot wear contact lens or have a job where glasses are inconvenient. This technique involves making a series of cuts in the cornea which flatten the cornea and improve focusing.

• Improved contact lens

Besides improved hard and soft contact lenses, there are also bifocal contacts on the market as well. In addition, there are now extended wear contacts available which can be worn continuously for up to two weeks.

• Pediatric ophthalmology

Dr. Rogers notes that there are several new developments which have improved children's vision. "Many children, especially those with congenital cataracts, have been given a chance for sight by improved cataract removal surgery." He explains that a small incision is made where the cornea meets the white portion of the

Radial keratotomy is another surgical procedure being used to improve near-sighted vision

eye. An instrument is then inserted to cut and suction away as much of the cataract as possible. When the cataract is removed, the incision is closed after injection of a fluid that returns the eye to its original shape.

"We are also saving the vision of premature infants more often by giving them Vitamin E. This water-soluble vitamin has prevented many of these premature infants from blindness." In addition, visually

continued on page 779



The patient is hooked up to the recorder which measures her visual evoked response (VER). This measurement of the electrical activity of the visual system can detect disease.



L. E. Leguire, Ph.D., Director of Electrophysiological and Eye Research at Children's Hospital, enters patient examination information into the computer which will file the data for future reference.

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Ophthalmology

The eyes have it

(continued)

impaired infants now have several other advantages unavailable to them several years ago. New products currently are being tested to help visually impaired children become more aware of their environment. For example, new products include a special sound-sensitive crawling mat designed to encourage visually impaired babies to crawl, a sound-locating device worn on the head to inspire the visually impaired patient to hold his or her head up, a black light under which bright materials are held for visually impaired children to grasp, and several toys that are either textured, reflect light or make noise.

• Intraocular lens implant

The perfecting of the intraocular lens is another area that deserves attention. Intraocular lens implants are especially for people who need a cataract extraction. Instead of prescribing thick lenses or contact lenses for the patients, a transparency is substituted for the crystalline lens of the eye. It actually provides more natural vision than either contact lenses or thick lenses.

• Improved instrumentation

Dr. Rogers emphasizes that much of the credit for improving eye-saving techniques belongs to improved instrumentation. "These extremely precise tools have enabled us to perform many delicate, sight restoring operations through microsurgery that we otherwise would be unable to do."

He also feels that the various technological advances being made in this field are largely due to an increased understanding of retinal physiology in general. "Our understanding of such vital questions as 'how do we see,' and 'how does the retina work,' is aiding us in the early detection and treatment of eye diseases."

This constant striving to better understand how the eye works is allowing ophthalmologists to perform their jobs even more effectively and to save and improve vision with even greater success.

Gina DiBlasio Cummins is Editor of Synergy and staff writer for the OSMA Journal.

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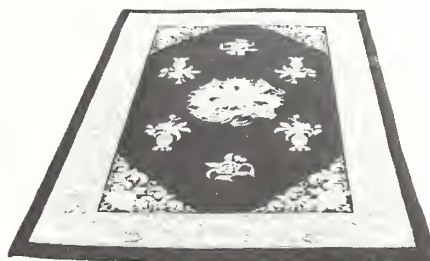
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BEFORE USING INDERAL (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

CONTRAINDICATIONS

1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless it is secondary to a tachyarrhythmia treatable with propranolol, 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE In congestive heart failure, inhibition with beta-blockade carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. In patients already receiving digitalis, propranolol may reduce the positive inotropic action of digitalis and may have an additive depressant effect on AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, in rare instances, cardiac failure has developed during propranolol therapy. At the first sign of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and observed closely: a) if cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol should be immediately withdrawn, b) if tachyarrhythmia is being controlled, patients should be maintained on combined therapy and closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of INDERAL therapy. Therefore, when discontinuance of INDERAL is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when INDERAL is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If INDERAL therapy is interrupted and exacerbation of angina occurs, it usually is advisable to reinstitute INDERAL therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Give special consideration to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Propranolol should be withdrawn slowly, since abrupt withdrawal may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta-blockade impairs the ability of the heart to respond to reflex stimuli. Except in pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery. In case of emergency surgery, the effects of propranolol can be reversed by administration of beta-receptor agonists such as isoproterenol or levaterenol, but such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), administer with caution, since propranolol may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta-receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA Propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia, especially in patients with labile diabetes. A precipitous elevation of blood pressure may accompany hypoglycemic attacks.

USE IN PREGNANCY Safe use in human pregnancy not established. Embryotoxic effects have been seen in animals at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if propranolol is administered, since it may occasionally produce hypotension and/or marked bradycardia resulting in vertigo, syncopal attacks, or orthostatic hypotension.

Observe laboratory parameters at regular intervals. Use with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type; thrombocytopenic purpura. **Central Nervous System:** lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia, visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. **Gastrointestinal:** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. **Allergic:** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. **Respiratory:** bronchospasm. **Hematologic:** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. **Miscellaneous:** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta-blocker (practolol) have not been conclusively associated with propranolol. **Clinical Laboratory Test Findings:** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

HOW SUPPLIED

TABLETS

—Each hexagonal-shaped, orange, scored tablet is embossed with an "I" and imprinted with "INDERAL 10," contains 10 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0421-81) and 1,000 (NDC 0046-0421-91). Also in unit dose package of 100 (NDC 0046-0421-99).

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7997/882

Reference: 1. Freis, E. D. Hypertension (Suppl. II) 3:230 (Nov-Dec) 1981.

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OSMA Publication Readers Speak Out . . .

By Karen S. Edwards

The Ohio State Medical Association's Department of Communications sent out a readership survey this past spring to find out whether or not the Department's publications are currently meeting the needs of the reader.

Almost 1,000 responses were received and computerized for analysis — enough to constitute a valid survey. The survey helped us, too, to develop a composite picture of you, the reader — who you are, your age group, your type of practice, your specialty. This, too, will help us to tailor the publications to meet your needs.

According to the results, 81% of our readers read or scan the *OSMAgram* all the time; 43% read or scan *Synergy*, (OSMA's patient publication) all the time and 68% read or scan the *OSMA Journal* all the time. Interestingly, only 50% indicated that they always read the *Journal of the American Medical Association*, and 54% indicated that they always read their specialty publications.

With regard to the *Ohio State Medical Journal*, the five departments read most often (in order) are: Clinical and Scientific articles; Legislative Update; News; Socioeconomic articles; and Colleagues in the News. If our readers were to change our current format, they would include: more Clinical and Scientific articles; more synopses of Clinical and Scientific articles from other publications; and a monthly Legislative Update. There also seems to be interest in instituting a practice management column; a new medical products column; and more issues of

the *Journal* based on a single theme, or subject.

The *OSMAgram*, the department's most highly-read publication, was reported as providing good coverage of association news and activities, and the legislative bulletin, included in each month's issue was found by over half of you to be valuable, in keeping you abreast of current legislative issues.

The OSMAGram, the department's most highly read publication, was reported as providing good coverage.

The use of *Synergy* as a patient education tool received a diverse response on our survey, probably a reflection of the number of different specialties responding (obviously, pathologists will not find the publication as useful as family practitioners, or pediatricians). However, 18% indicated that they always used *Synergy* as a patient education tool; 23% indicated that they sometimes do; and 17% indicated that they do use *Synergy* when appropriate. The respondents found the following types of articles in *Synergy* to be most helpful in patient education (again, in order): Health awareness/disease prevention articles; the healthful hints

column; safety articles; articles that explain the different specialties, and those that explain the different body parts.

From the responses we received, it appears that most of our readers are physicians who are in the 51-60 age bracket, and engaged in solo practice. The largest number of respondents were family practitioners, but OB/GYNs, pediatricians, general surgeons and internists also were well represented.

The results of the survey have been reviewed by the OSMA's Communications Committee, and soon will be taken under advisement by the new *Journal* Editorial Advisory Committee.

The Committee, appointed by President C. Douglass Ford, M.D., Toledo, and chaired by Sylvan L. Weinberg, M.D., Dayton, will provide input into the *Journal's* editorial structure, and will be responsible for sending out for peer review, those articles submitted by members, which are of a clinical and scientific nature.

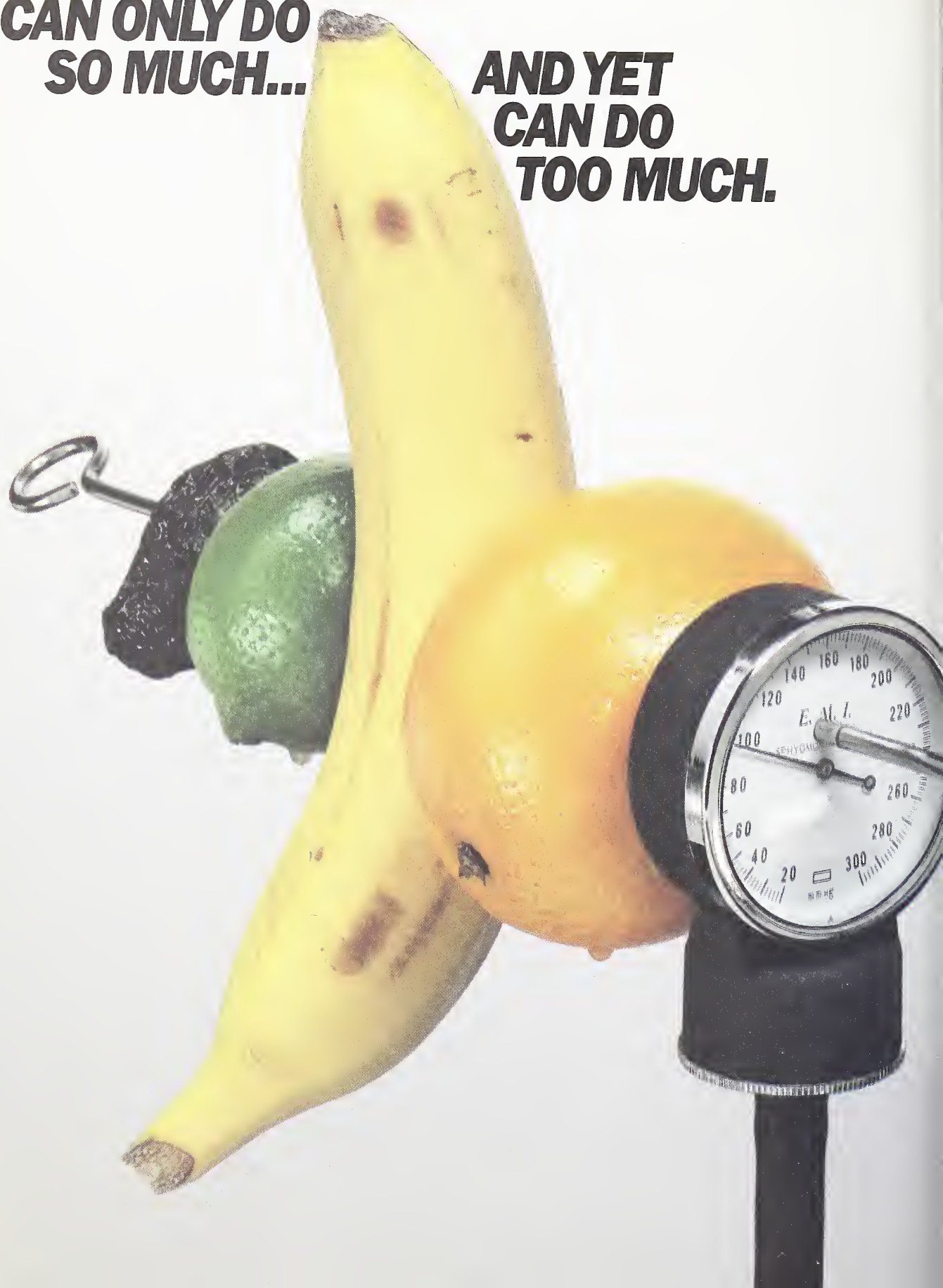
Karen S. Edwards is Executive Editor of the Ohio State Medical Journal

Correction

In the September issue of the *Ohio State Medical Journal*, the article "Business Interest," by Robert Holcomb, identified the company NCR as the National Cash Register Company. In fact, the company has dropped that name and is now officially known as NCR.

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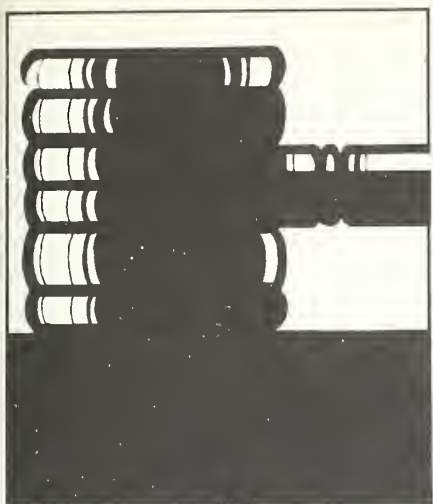
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council proceedings

PROCEEDINGS OF THE COUNCIL

September 11, 1982

A regular meeting of the Council of the Ohio State Medical Association was held Saturday, September 11, 1982, at the OSMA Headquarters, 600 South High Street, Columbus, Ohio.

Those present were: C. Douglass Ford, M.D., Toledo; S. Baird Pfahl, Jr., M.D., Sandusky; Stewart B. Dunsker, M.D., Cincinnati; David A. Barr, M.D., Lima; John E. Albers, M.D., Cincinnati; Herman I. Abromowitz, M.D., Dayton; Thomas R. Leech, M.D., Lima; Benjamin H. Reed, M.D., Wauseon; Edward G. Kilroy, M.D., Cleveland; J. James Anderson, M.D., Youngstown; H. Judson Reamy, M.D., New Philadelphia; Carl E. Spragg, M.D., New Concord; A. Burton Payne, M.D., Ironton; D. James Hickson, M.D., Mt. Gilead; D. Ross Irons, M.D., Bellevue; Joseph L. Kloss, M.D., Akron; Frank Papay, Medical Student Section, Tallmadge; James E. Pohlman, Esq., Columbus; Oscar W. Clarke, M.D., Chmn., AMA Delegation, Gallipolis; Rose Vesper, President, OSMA Auxiliary, New Richmond; John H. Ackerman, M.D., Dir., Ohio Dept. of Health, Columbus; and David W. Pennington, President, PACO, Worthington.

Those present from the OSMA Staff were: Hart F. Page, CAE; Herbert E. Gillen; Robert D. Clinger; Katherine E. Wisse; D. Brent Mulgrew, Esq.;

Rebecca J. Doll; Gail E. Dodson; Robert E. Holcomb; Carol W. Mullinax; Eric Burkland; Michael L. Bateson; Catherine M. Costello, Esq.; William E. Fry; Louis N. Saslaw; and Carol M. Maddy.

Announcements by President Ford

The Council was called to order by President Ford. Dr. J. James Anderson, M.D., Youngstown, was appointed by the Council to serve until the next Annual Meeting of the House of Delegates as Sixth District Councillor, to fill the vacancy created by the resignation of Dr. Joseph P. Yut.

The Council voted to thank Dr. Yut for his past services.

The Council ratified Dr. Ford's appointment of the following members to the Committee on Health Planning Advisory Panels authorized by the House of Delegates under Resolution No. 23-82: Alford C. Diller, M.D., Van Wert, Chairman; Stanley J. Lucas, M.D., Cincinnati; Harold Lupin, M.D., Columbus; Frederick T. Suppes, M.D., Gates Mills.

The Council received and filed for information a communication dated August 20, 1982, from the Congress of Medical Specialty Societies on Flex I & II examinations.

Dr. Ford announced the nomination of Dr. Clarke to the AMA Committee on Medico-Legal Problems.

He announced the appointment of Dr. James C. McLarnan, Mt. Vernon, and Dr. Paul S. Metzger, Columbus, to the State Health Coordinating Council.

The minutes of the July 17 and July 30, 1982 meetings of the Council were approved as previously distributed.

Mr. Page reported on his Washington visitation of September 8, 1982 with regard to pending FTC legislation.

The Executive Director presented a letter dated July 26, 1982, from James B. Zimmerman, President of the Lawrence County Medical Society. The communication officially nominated A. Burton Payne, M.D., Ninth District Counselor, for the position of President-Elect of OSMA.

Dr. Abromowitz and Mr. Pennington presented a review of the operations of Physicians Administrative Corporation of Ohio.

Financial and Membership Department

Mrs. Wisse reported gains in membership over the previous year.

The report of the Financial and Membership Department was presented in writing.

Committee on Auditing and Appropriations — Dr. Payne presented the minutes of the September 10, 1982 meeting of the Committee on Auditing and Appropriations.

The Committee recommended and the Council approved the following actions:

- that the OSMA purchase the outstanding indebtedness of cars currently under lease, with appropriate security agreement, and accept proposal "A" whereby OSMA receive the interest on the existing indebtedness;
- that the Retired Life Reserve plan of PICO with an annual deposit of \$25,337 for the designated staff members be approved;
- that the parking lot be sealcoated and lined at a cost of \$1042;
- that the Battelle Memorial Institute proposal costing \$15,000 be approved as outlined and that Battelle be directed to consider the capability of OSMA marketing this program in a computerized micro system;
- that the contract with Dr. Roger Blackwell be discontinued with a negotiated settlement of the fees charged;
- that the Task Force on Marketing and Competition be encouraged to pursue ways of working together with the Academy of Medicine of Cincinnati on patient/consumer attitude matters;
- that the OSMA pool its checking accounts into a single concentration account using the Zero Balance Accounting and Automated Funds Investment programs of the Huntington National Bank and that the interest earned on these investments be allocated and annotated to the appropriate accounts;

continued on page 787



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Council Proceedings

(continued)

Task Force on Marketing and Competition — The minutes of the August 12, 1982 meeting of the Task Force on Marketing and Competition were presented in writing and received for information.

Councilor Reports

The Councilors reported on the activities in their respective districts.

Legal Counsel Report

Mr. Pohlman presented the legal counsel report.

Ohio Department of Health

Dr. John Ackerman, Director, Ohio Department of Health, addressed the Council.

OSMA Auxiliary Report

Mrs. Rose Vesper, President of the OSMA Auxiliary, presented her report in writing for the information of the Council. Mrs. Vesper discussed current activities of the Auxiliary.

Constitution and Bylaws Amendments

Amendments to the Bylaws of the Montgomery County Medical Society were presented by Mr. Mulgrew and were approved.

There being no further business, the meeting was adjourned.

ATTEST: Hart F. Page, CAE
Executive Director

/slp
Sept. 28, 1982

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Indications: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency; or conditions resulting in increased needs for essential vitamins and minerals.

Contraindications: Hypersensitivity to any component.

Warnings: Not for pernicious anemia or other megaloblastic anemias where vitamin B₁₂ is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B₁₂ deficiency who receive supplemental folic acid and who are inade-

quately treated with B₁₂.

Precautions: General: Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. **Information for the Patient:** Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. **Drug and Treatment Interactions:** As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.

Adverse Reactions: Adverse reactions have been reported with specific vitamins and

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minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.

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References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease*, op. cit., p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, op. cit., pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med* 89 (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.

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OPHTHALMOLOGY: December 2-3; Bunts Auditorium, Cleveland Clinic, 9500 Euclid Avenue, Cleveland 44106; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$190, \$95 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll Free in Ohio 1-800-762-8172; outside Ohio 1-800-762-8173.

January

URO-RADIOLOGY SEMINAR:

January 13-15; Westin Hotel, Cincinnati; sponsor: University of Cincinnati Medical Center; 19 credit hours; fee: \$200; contact: Division of Urology, M.L. No. 589, University of Cincinnati Medical Center, 231 Bethesda Avenue, Cincinnati 45267.

SURGICAL MANAGEMENT OF GASTROINTESTINAL PROBLEMS:

January 27-28; Bunts Auditorium, Cleveland Clinic; sponsor: Cleveland Clinic Educational Foundation; 12 credit hours; fee: \$185, \$90 for physicians-in-training; contact: Center for CME, Cleveland Clinic Educational Foundation, 9500 Euclid Avenue, Cleveland 44106, phone: Toll Free in Ohio 1-800-762-8172; outside Ohio 1-800-762-8173.

November

MEDICINE AND THE LAW:

November 20; Christ Hospital Auditorium, Cincinnati; sponsor: Christ Hospital, Cincinnati; 6.5 credit hours; fee: \$60; contact: Ms. June Hosick, Christ Hospital, Cincinnati 45219, phone: 513/369-2000.

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age 65; died June 26, 1982; member OSMA and AMA.

JOHN A. DOLE, M.D., Ironton; Ohio State University College of Medicine, 1938; age 68; died August 24, 1982; member OSMA and AMA.

ALEXANDER KAKIS, M.D., Columbus; Latvijas University of Medicine, Riga, Latvia, 1937; age 70; died August 31, 1982; member OSMA and AMA.

Past President of State Medical Board dies

SANFORD PRESS, M.D., Steubenville; Wayne State University School of Medicine, Detroit, 1939; age 70; died September 24, 1982; member OSMA and AMA.

EDWARD W. SACHS, M.D., Dayton; Loyola University Stritch School of Medicine, 1932; age 75; died August 14, 1982; member OSMA and AMA.

MORRIS W. SELMAN, M.D., Toledo; Wayne State University School of Medicine, 1937; age 70; died September 5, 1982; member OSMA and AMA.

NORMAN SHUMWAY, M.D., Cleveland; University of Pennsylvania School of Medicine; age 76; died July 13, 1982; member OSMA.

JOHN HAROLD SMITH, M.D., Sebring; University of Louisville School of Medicine, Louisville, 1935; age 76; died August 19, 1982; member OSMA and AMA.

CARL WEIHL, M.D., Cincinnati; University of Cincinnati College of Medicine, 1944; age 62; died September 13, 1982; member OSMA.

JOSEPH R. WILLIAMS, M.D., Eaton; Ohio State University College of Medicine, 1936; age 71; died September 13, 1982; member OSMA and AMA.

RALPH D. YATES, M.D., Piqua; Ohio State University College of Medicine, 1926; age 81; died August 15, 1982; member OSMA and AMA.

JAMES B. ZIMMERMAN, M.D., Ironton; University of Maryland School of Medicine, Baltimore, 1958; age 54; died August 3, 1982; member OSMA and AMA.

SADRI ALAVI, M.D., Steubenville; Faculty of Medicine, University of Teheran, Teheran, Iran, 1957; age 58; died September, 1982; member OSMA and AMA.

CHESTER H. ALLEN, M.D., Portsmouth; Ohio State University College of Medicine, 1934; age 73; died July 26, 1982; member OSMA and AMA.

THEODORE ALLENBACH, M.D., Columbus; Ohio State University College of Medicine, 1933; age 76; died September 7, 1982; member OSMA and AMA.

IRWIN ALTENBURG, M.D., Dayton; University of Cincinnati College of Medicine, 1943; age 67; died September 17, 1982; member OSMA and AMA.

WILLIAM BAIRD, M.D., Cuyahoga Falls; Ohio State University College of Medicine, 1943; age 63; died August 12, 1982; member OSMA and AMA.

HARRY W. BECK, M.D., Canton; Ohio State University College of Medicine, 1925; age 83; died August 22, 1982; member OSMA.

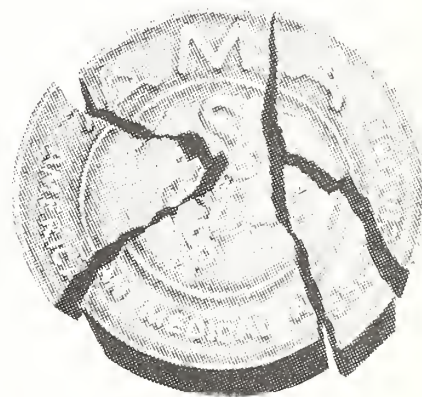
GRACE BROWN NUNEMAKER, M.D., Columbus; Ohio State University College of Medicine, 1936; age 84; died August 31, 1982; member OSMA and AMA.

DALVIN CAHILL, M.D., Waverly; Ohio State University College of Medicine, 1934; age 84; died August 6, 1982; member OSMA and AMA.

JOSEPH F. CORSARO, M.D., Dayton; Case Western Reserve University School of Medicine, 1938; age 70; died September 10, 1982; member OSMA and AMA.

REGINAL DANIEL, M.D., Dayton; Meharry Medical College School of Medicine, Nashville, Tennessee, 1950;

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Ohio State Medical Journal Manuscript Guidelines

1. EXCLUSIVE PUBLICATION. Articles are accepted for publication with the understanding that they are contributed solely to this *Journal*. Permission for subsequent publication elsewhere must be obtained in writing from the Editor and from the Author.

2. CORRESPONDENCE. Address all correspondence relating to publication of scientific papers to: The Consulting Medical Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

3. MANUSCRIPTS. (a). Manuscripts should be submitted in the original on standard 22 x 28-cm (8 1/2 x 11-inch) white typing paper.

(b). A copy of the manuscript should be retained by the Author.

(c). The entire text including lists of REFERENCES should be TYPED DOUBLE OR TRIPLE SPACED with margins of at least one inch on all sides.

(d). Tables, charts, and figures (illustrations) should be submitted separately from that text. They should be identified by number and by concise, descriptive titles. In the text, reference to them should be by number, eg, (Fig. 1).

4. ILLUSTRATIONS. (a). Illustrations (photographs, drawings, graphs, and tables) will be submitted to the printer for an estimate of cost. The *Journal* will assume \$10 of this expense and the author will be billed by The *Journal* for the remainder.

(b). Each illustration should bear the figure number and the author's name on the back. When pertinent, the top of the photograph should be indicated. Do not clip, write on the back with a hard pencil, or otherwise mutilate the prints.

(c). Legends for the figures should be written on separate paper.

(d). The author must affirm that he has written releases on all photographs in which patients can be identified.

5. ABSTRACTS. A short (100-word maximum) abstract should be included with the article. It should cover the main points so that the reader may readily obtain the gist of the article.

6. SUMMARIES. The summary should be a concise restatement of the information given in the body of the article.

7. REFERENCES. (a). Lists of references should be at a minimum to conserve space and expense and be limited to those essential to the subject and to which actual reference is made in the text. The Editor reserves the right to reduce the number when necessary.

(b). References should be listed in the order of their appearance in the text.

(c). Authenticity and accuracy are the responsibilities of the Author.

(d). Each journal reference should include in this order: Author's surname and initials, title of article, name of journal (abbreviated in accordance with standard usage), volume number, inclusive page number, and year.

"2.Doe J, Roe RX: How to go about it. *Ohio State MJ* 13:24-30, 1920"

Each textbook reference should include, in this order: Author's surname and initials, title of the book (capitalize all main words), edition, place of publication, name of the publisher, year of publication, volume, if more than one has been published, and page.

"5 Osler W: *Modern Medicine*, ed 3, Philadelphia, Lea & Febiger, 1927, vol 5, p 66."

8. IDENTIFICATION OF PATIENTS. Names, initials, hospital numbers, or any other identifiable labels, should not be used. It is preferable to identify patients for the purpose of publication by the use of numbers in series for the study being reported.

9. METRICATION. All measurements must be in metric units. English units should be given in parentheses following the metric in all cases where the measurement was originally done in English units.

10. EDITING OF MANUSCRIPT. Following acceptance of a manuscript for publication, it will be copy edited in conformance with the editorial standards of the American Medical Association, which *The Journal* follows. The copy-edited manuscript will be returned to the Senior Author for approval. At that time, he is asked to make all corrections and to have the manuscript retyped. Any changes, other than typographical errors, made by the Author after the manuscript is set in type will be billed to him at \$2 per line.

11. REPRINTS. An order blank for reprints with a table covering cost will be sent with the galley proofs to the Senior Author. *The Journal* does not profit on reprint orders.

12. EDITORIAL ASSISTANCE. Ms. Carol J. Wiley, *Journal* Editorial Assistant, stands ready to assist the Author in preparing his manuscript. For his own assistance, however, the Author is encouraged to consult standard texts on medical writing, such as the *Style Book and Editorial Manual*, prepared by the Scientific Publications Division, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610.

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Contraindications: Known hypersensitivity to drug

Warnings: Warn patients that mental and/or physical abilities required for tasks such as driving or operating machinery may be impaired, as may be mental alertness in children, and that concomitant use with alcohol or CNS depressants may have an additive effect. Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage. Withdrawal symptoms (including convulsions) reported after abrupt cessation of extended use of excessive doses are similar to those seen with barbiturates. Milder symptoms reported infrequently when continuous therapy is abruptly ended. Avoid abrupt discontinuation, gradually taper dosage.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: In the elderly and debilitated, and in children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression, suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants, causal relationship has not been established clinically. Due to isolated reports of exacerbation, use with caution in patients with porphyria.

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16 Bruce Park Avenue
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The Ohio State Medical Journal
600 South High Street
Columbus, Ohio 43215
Telephone: 614/228-6971

Address All Correspondence, Address Change, & Reprint Request (unless otherwise noted): Executive Editor, The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215. Phone: 614/228-6971.

Published monthly under the direction of The Council for and by members of The Ohio State Medical Association, 600 South High Street, Columbus, Ohio 43215, a scientific society, nonprofit organization, with a definite membership for scientific and educational purposes.

1981 Subscription: \$15 per year, single copy \$2 (outside U.S. \$20 and \$3).

Send address changes to: The Ohio State Medical Journal, 600 South High Street, Columbus, Ohio 43215.

Entered as second class matter July 5, 1905, at the Post Office at Athens, Ohio, under the Act of Congress of March 3, 1879. Acceptance for mailing at special rate of postage provided for in Section 1103, Act of Oct. 3, 1917. Authority July 10, 1918. Second Class Postage paid at Athens, Ohio.

The Journal does not assume responsibility for opinions expressed by the essayists. Advertisers must conform to policies and regulations established by The Council of the Ohio State Medical Association.

Publication office: 900 East State Street, Athens, Ohio 45701.

Printed by
The Lawhead Press, Inc., Athens, Ohio

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Letters ...to the editor

To the Editor:

I read with concern the letter to the Editor appearing on page 675 of the October issue of the *Ohio State Medical Journal* entitled "ADVANCE divorce" from William E. Donze, M.D., of Middleburg Heights, Ohio. This letter is almost identical to a letter Dr. Donze wrote to me dated August 12, 1982, asking OMIM to terminate his ADVANCE Plan Agreement.

Although such requests for termination are very few, we take them very seriously. Immediately upon receipt of Dr. Donze's letter, I requested that our local Professional Relations Field Representative arrange to meet with Dr. Donze and discuss the specific case that caused his decision to terminate. Our local representative obtained the back-up information regarding the case and found that the original payment was incorrect and an additional payment adjustment was promptly authorized.

Furthermore, the primary reason for the significant difference between OMIM's payment and Dr. Donze's charge was simply because the subscriber's contract is an 80% UCR type contract. Therefore, Dr. Donze is entitled to bill the patient the 20% differential. In effect, we agree that Dr. Donze's fee for the service in question is reasonable and are paying our 80% liability.

It is unfortunate that Dr. Donze took this one case as the basis for deciding to no longer be included in the ADVANCE Plan. Our representative is continuing to attempt to discuss this with Dr. Donze in an effort to reinstate him in the ADVANCE Plan.

Sincerely,
/s/Neal L. McCue
Vice President
Health Affairs
Blue Shield
Columbus, Ohio

To the Editor:

Congratulations!

Congratulations on an excellent article saying so well what needs to be said. ("Can Private Practice Survive . . . Or Does Anybody Care?" John H. Boyles, Jr., M.D., September *Journal*.)

I pray that your readers will take your advice to heart and become "involved" and make the necessary "personal commitment" to protect, preserve, and foster individual freedom.

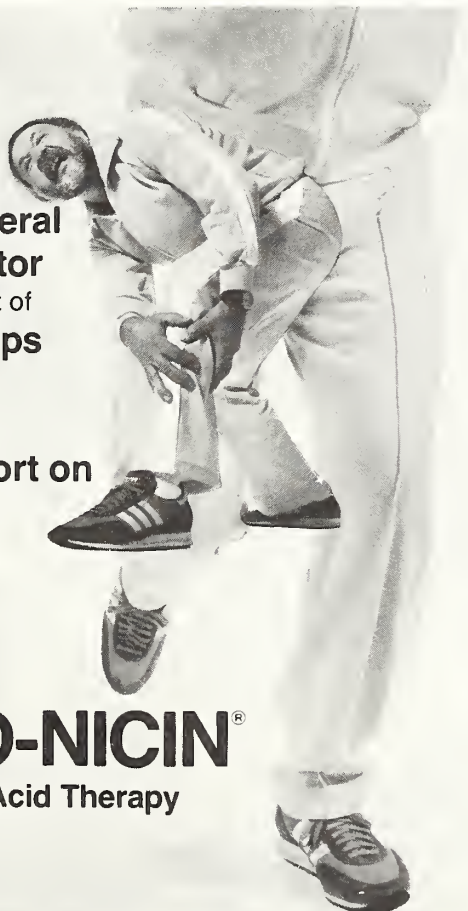
One cannot help but wonder how many of us TRULY comprehend the "meaning" of freedom and the "price" freedom demands for its existence and propagation.

Again, congratulations.

Gratefully,
/s/N.M. Camardese, M.D.
Norwalk, Ohio

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Pyridoxine HCL (B-6)	10 mg.

DOSE: 1 to 3 tablets daily.

AVAILABLE: Bottles of 100, 500.

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Each blue tablet contains:

Nicotinic Acid	100 mg.
Niacinamide	75 mg.
Ascorbic Acid	150 mg.
Thiamine HCL (B-1)	25 mg.
Riboflavin (B-2)	2 mg.
Pyridoxine HCL (B-6)	10 mg.

DOSE: 1 to 5 tablets daily.

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Indications: For use as a vasodilator in the symptoms of cold feet, leg cramps, dizziness, memory loss or tinnitus when associated with impaired peripheral circulation. Also provides concomitant administration of the listed vitamins. The warm tingling flush which may follow each dose of LIPO-NICIN® 100 mg. or 250 mg. is one of the therapeutic effects that often produce psychological benefits to the patient.

Side Effects: Transient flushing and feeling of warmth seldom require discontinuation of the drug. Transient headache, itching and tingling, skin rash, allergies and gastric disturbance may occur.

Contraindications: Patients with known idiosyncrasy to nicotinic acid or other components of the drug. Use with caution in pregnant patients and patients with glaucoma, severe diabetes, impaired liver function, peptic ulcers, and arterial bleeding.

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avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE**

REACTIONS: Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. In the male: Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchidism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D., R. Witherington, M.D., I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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DONAVIN A. BAUMGARTNER, M.D., was appointed medical director of St. Luke's Emergency Center of Solon. Dr. Baumgartner continues as medical director of St. Luke's Hospital emergency room. He is a senior instructor in surgery at Case Western Reserve University Medical School and an instructor of advanced trauma life support for the American College of Surgeons.

ROGER JENKINS, M.D., Lima, and **RAYMOND S. LUPSE, M.D.**, Youngstown, were elected to the board of trustees of the American Cancer Society's Ohio Division. Dr. Jenkins is currently the crusade chairman of the Allen County Unit of the American Cancer Society. Dr. Lupse, an obstetrician-gynecologist, is chairman of the Mahoning County Unit Medical Affairs Committee.

JAMES F. KING, M.D., North Canton, was appointed professor of medicine at Northeastern Ohio Universities College of Medicine. Dr. King is chairman of the

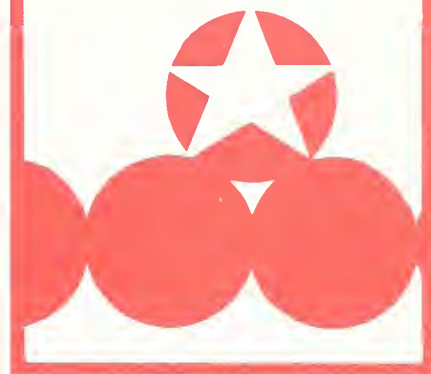
gastroenterology division at NEOUCOM, clinical assistant professor of medicine at Case Western Reserve University, and is on the teaching staffs of Akron City and Akron General Hospitals.



W. J. Lewis, M.D. . . . Music man

W. J. LEWIS, M.D., Dayton, was elected to the board of trustees of the Dayton Philharmonic Orchestra Association.

COLLEAGUES IN THE NEWS

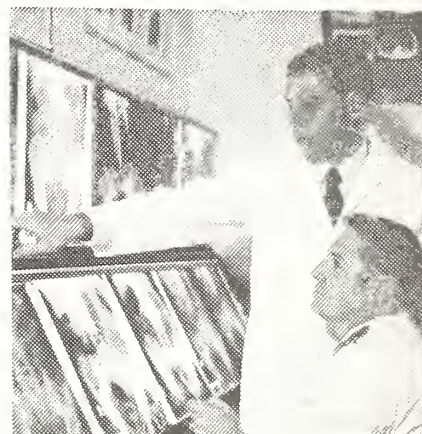


DONALD W. LENHART, M.D., Sandusky, was appointed chairman of the medical staff of Providence Hospital. Dr. Lenhart is a general surgeon.

THOMAS R. WERNER, M.D., Cincinnati, was elected president of the Ohio Psychiatric Association. Dr. Werner is on the board of the Cincinnati Psychiatric Society.

AN ATTRACTIVE ALTERNATIVE TO PRIVATE PRACTICE — AIR FORCE MEDICINE

Did you go to medical school to become a doctor or an office manager, supply clerk, or repairman? If you want to concentrate on your medical practice and leave the administration to someone else, then Air Force medicine can be an attractive alternative to your private practice. You see, the Air Force uses a group practice system of health care. This system allows maximum contact between patient and physician with a minimum of administrative responsibilities. Nurses and technicians take care of the paperwork while you take care of the patients. You'll get to use the skills gained through years of education; to stay abreast of new methods and techniques; and, for qualified physicians, to specialize. These benefits, along with our excellent employment package, make Air Force medicine an attractive alternative to private practice. Find out how you can be a part of the Air Force health care team. We'll answer all your questions promptly and without obligation.



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New procedure of attaching prosthesis is underway

A new method of permanently attaching prostheses is offering hope of a more normal lifestyle to people who have lost facial or body parts due to illness or injury.

The surgical procedure which attaches the prosthesis to the patient's tissue with small gold rings, was developed at the University of Texas M.D. Anderson Hospital and Tumor Institute and was recently used to attach an artificial nose to a 46-year-old cancer patient from Cleveland, Texas. It is believed to be the first such attachment in the world.

The developer of the procedure, Dr. Ariyadasa Udagama, an associate professor of dental oncology at UT M.D. Anderson Hospital, says the procedure will be used to attach other facial prostheses and may soon be used to attach artificial breasts. It may

eventually be used to attach permanently other artificial parts like fingers and even arms, he predicts.

The new procedure offers physicians and dentists another option to reconstruction of lost body parts. Previously, such reconstruction could be done by using the patient's tissue alone, by using artificial body parts covered with the patient's tissue, or by gluing on an artificial part. Now physicians can combine those options by attaching a prosthesis to the patient's own tissue.

Development of competitive health plans encouraged

The federal government has awarded grants totaling almost \$1 million to five states to encourage the development of competitive health plans for Medicaid recipients.

Sponsored by the government's Health Care Financing Administration, the five demonstration projects are aimed at encouraging competition among insurers and providers by giving Medicaid recipients a choice of health plans. The states receiving the grants are Florida, Minnesota, Missouri, New Jersey, and New York.

The projects vary in design. Three allow recipients to continue using fee-for-service care, if they so choose; two require participating in an alternative plan. All operate by paying a capitated fee in advance for the health care of each enrollee.

Each project will last four years. After that, the government will measure the savings generated through capitation payment versus the fee-for-service care the recipients previously received.

The federal government is expected soon to announce a similar program to contract with states to encourage the development of competitive systems for Medicare recipients. Next year, the federal government probably will award grants to more states to promote competition in Medicaid further.

DMSO use generates controversy

Questions about the safety and efficacy of dimethyl sulfoxide (DMSO) for medicinal use continue to generate controversy. Many reports have proclaimed DMSO a miracle drug and medical panacea, while others have suggested that it is a hoax.

Among new investigations on DMSO, according to an AMA Council on Scientific Affairs report in the *Journal of the AMA*, is a multiclinic controlled study of the drug in the treatment of cutaneous ulcers in scleroderma — a connective tissue disease.

Trials are also under way at the U. of California and the U. of Oregon on the usefulness of DMSO in head injury. The FDA also has approved investigational studies of the drug in other conditions primarily in acute injuries such as sprains and strains.

In the meantime, according to the AMA Council report, some state legislatures have passed laws "legalizing" the manufacture, prescription, and use of DMSO under certain conditions within their respective states. This has happened despite the scientific judgment of the Food and Drug Administration (FDA) and in some cases the medical opinion

and advice of their state medical societies.

In some states, medical societies even favored legalizing DMSO. Such legislation does not make the drug available on prescription automatically, and patients cannot obtain it necessarily by traveling to the states with such laws.

The Department of Professional Regulation of Florida (a state that has legalized DMSO) recently found it necessary to warn physicians and other licensed health care practitioners against prescribing industrial or veterinary grade DMSO for human use.

According to the report, the FDA and the Arthritis Foundation have warned physicians and the public of the potential hazard of using the industrial product because it can carry impurities through the skin.

The usual adverse reactions to the use of DMSO on the skin include redness and itching. A local or generalized rash also has been reported. The most noticeable side effect is a garlic-like taste and odor on the breath that occurs within a few minutes after administration.

a compilation of the latest developments, reports and products of interest to physicians.

**edited by
Gina DiBlasio Cummins**

Organ retrieval program goes nationwide

A Civil Air Patrol organ retrieval program pioneered by a Pennsylvania physician will go nationwide within the next six months, providing transplant programs across the country with major assistance in their organ procurement efforts.

Since the program began, a network of about 1,000 volunteer pilots has flown 17 transplant missions, with the most recent involving transporting a heart from Morgantown, W. Va., to Pittsburgh. Each mission originates from CAP command headquarters or from the office of Phillip Breen, M.D., a surgeon at Geisinger Medical Center in Danville and a national CAP

commander.

Each flight has been authorized by the Air Force, which provides insurance coverage and reimbursement for fuel and maintenance. The arrangement, which the Air Force recently authorized, is similar to the one under which the CAP flies search-and-rescue missions.

One side benefit of the CAP's experience with search-and-rescue and emergency services is its strong ham radio net, which Dr. Breen expects to contribute to the transplant program's effectiveness.

Dr. Breen emphasized that the CAP is not interested in taking over from

any other volunteer group that currently is helping with organ retrieval. "But with 35,000 adult members, interstate connections, and radio backup, I think we're in a unique position to fill in the gaps, particularly in moving organs and tissues from rural centers to metropolitan areas," he said.

"We really expect this to expand and mature into a major solution for the transportation problems faced by transplant programs," Dr. Breen said. "It's definitely time to move away from relying on one of the traditional solutions, the trunk of a speeding police car."

Notice to All OSMA Members

Your Membership in the Ohio State Medical Association and American Medical Association, including subscriptions to *The Ohio State Medical Journal* and *The Journal of the AMA*, will expire on December 31, 1982. Here's how to renew:

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OSMA dues are \$195. AMA membership dues are \$315. Check with your local Secretary-Treasurer to determine the amount of your County Society dues. Ohio Medical Political Action Committee-American Medical Political Action Committee (OMPAC-AMPAC) dues are \$50. OMPAC-AMPAC membership is recommended.

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As part of the privileges and services offered to all members of the OSMA, you will receive a year's subscription to *The Ohio State Medical Journal*, the *OSMAgram* and *Synergy*, without extra cost. Dues-paying members of the AMA will receive a year's subscription to *The Journal of the AMA* and the *American Medical News*.

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For further information on medical society membership contact:
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22nd Maternal Mortality Report

*By the OSMA's Committee
on Maternal and Neonatal Health*

OSMA's Committee on Maternal and Neonatal Health presents this 22nd survey on maternal mortality, both as an update and in compliance with the directive creating the Committee in 1954.¹

The data contained in this report comprises activities recorded from the fall of 1979 until May 30, 1982.

However, the statistical reporting will cover years 1977 to 1979, inclusive. A number of cases outstanding have caused us to delay publication of complete reports.

Activities

The Committee has averaged 22 members representing each of the Councilor areas of Ohio and also providing an excellent professional input from the field of family practice, internal medicine, obstetrics and gynecology, and pathology.

Prior to this report, six members of the Committee appeared before the Council to testify in behalf of the continuance of the Ohio Maternal Mortality Study.

During 1980, 1981 and 1982 three regular meetings (the 66th, 67th and 68th) were held. A total of 56 maternal death cases came before the Committee during that time for study, evaluation and classification.

In addition to this work, programs were enhanced by personal appearances of members of the Maternal and Child Health Division, Ohio Department of Health, (Drs. Linyear, Quilty, Platt), the Ohio section, Dist. V, American College of Obstetrics and Gynecology, etc. Maternal and neonatal problems were predominant in discussion and management, including trends in home/clinic births.

The Committee also made recommendations to the Council regarding the use of diagnostic ultrasound in pregnancies: discussed, recommended and participated in the planning and implementation of the symposium on "Alternate Birth Facilities"; discussed guidelines for "Pregnancy Disability Problems" (see OSMA Journal, June, 1981, page 347); and considered and discussed "Teenage Pregnancy Problems" (see OSMA Journal, Aug., 1981, page 477).

At the direct request of Council, the Committee also reported on matters pertaining to "home delivery deaths"; "efficacy of the nurse-midwife in practice"; past activities of the Committee versus goals for the future, etc.

Members also attended and participated in various national and

OHIO MATERNAL MORTALITY STUDY

STATISTICS FOR 1977-1979 (Inc.)

TOTAL LIVE BIRTHS IN OHIO, 1977-1979	488,820 ³
FETAL DEATHS, 1977-1979	4,597 ³
Total cases studied (1977-1979)	50
CASES NOT STUDIED, INCOMPLETE INFORMATION	21
Undetermined	0
NONMATERNAL DEATHS	12
MATERNAL DEATHS (Classified)	38
Nonwhite	17
White	21
Age:	
Teens	6
20s	21
30s	9
40s	2
Parity:	
Primigravidae	10
Multiparae	18
Unknown	0
Place of Death:	
Hospital	35
Home	2
Other	1
Place of Birth:	
Hospital	29
Home	9
Other	0
Type of Delivery:	
Not recorded	0
Operative	23
Nonoperative (spontaneous)	8
Not delivered	7
Route of Delivery:	
Not recorded	0
Vaginal	13
Cesarean	17
(antemortem)	17
(postmortem)	0
Laparotomy (ectopic preg.)	1
Not delivered	7
Case Classification: (when death occurred)	
Not known	0
Group I (fr. concept. to 20th wk.)	2
Group II (fr. 20th wk. to 28th wk.)	2
Group III (fr. 28th wk. through term)	3
Group IV (postabortal, postpartum)	31

state meetings, as well as a national meeting in Washington, to explore the feasibility of a nationwide epidemiologic study of maternal deaths.

Projects

Since its inception, the Committee has focused its attention on improving obstetrical care, chiefly by educating the public, physicians, residents, nurse-midwives, nurses, and medical students. Ultimately, as we have found in 28 years, there is an appreciable reduction in maternal and perinatal mortality and morbidity in Ohio.

The educational means we employed were multiple: publication of anonymous case reports with conclusions; publication of minimum standards of OB care; preparation and display of exhibits; distribution of reprints to physicians and medical students; lectures and informal talks to the medical, paramedical and the lay public; articles in the news media, etc.

Some of these we hope to revive, the rest we will continue.

The Committee's last exhibit entitled, "A 20-Year Survey of Ohio Maternal Deaths," was displayed in Cincinnati during the 1980 OSMA meeting. Previously an exhibit, "Teenage Maternal Deaths in Ohio," was displayed during the 1979 OSMA meeting in Dayton.

A subcommittee is currently preparing the 8th revision of "Guiding Principles for Obstetric Care,"² which provides a set of minimum standards to evaluate avoidable factors in the study of maternal deaths. The document was first approved by Council in 1957.

We are also working to formulate and complete material for a 25-year survey of Ohio maternal deaths. One area (Montgomery County) has been on a nonreporting status for the past several years; many "outstanding cases" have accumulated. Presently we have plans to correct the deficiency and acquire the necessary data.

However, the statewide maternal study continues; case discovery and

Ohio Maternal Mortality Study (continued)

identification still offer a fair problem which is common to all state studies. Personnel operating similar studies pay \$50 to each investigator developing a case for study; their committees run an annual budget of \$8,500 to \$10,000; ours is \$1,800, with voluntary work from each Committee member, and remuneration for mileage and meals related to meetings.

Statistics

Statistics for the years 1975 and 1976 were reported to Council in the last summary (21st survey). To expedite this document, the following statistics are published for three years, 1977-1979 inclusive:

Discussion

In Ohio, there were 488,820 live births reported during 1977, 1978, and 1979. From information on available cases, the Committee classified 38 maternal deaths for the three years. The maternal mortality rate was 0.09 per 1,000 births, or 0.9 per 10,000 live births for 1977-1979. Obviously, this figure lacks both character and reliability due to the 21 outstanding cases! The last figure reported for the year 1976 was 0.1546 deaths per 1,000 live births.

Even though these statistics may not be completely accurate for the three-year period, certain interesting features may be salvaged from the report.

There were six teenage maternal deaths among the 38 classified! Seventeen patients died following **antemortem** cesarean section; there were no postmortem cesarean operations. Prenatal care reported among 29 selected patients revealed 19 had **adequate** care, six received **inadequate** care, while four received none at all.

The **preventability** factors among the 38 classified maternal deaths revealed majority (21) of the cases died nonpreventable deaths (unavoidable catastrophies). Among the preventable deaths, eight of the 17 were due to

Autopsies	29
(Includes 9 coroners)	
Prenatal care (apparent from data sheets)	
None	4
Unknown or not reported	2
Adequate	19
Inadequate	6
Excluded (ectopic preg. and abortion)	7
Classification of preventability:	
Nonpreventable	21
Preventable (avoidable factor)	17
Patient responsibility (P ₁)	7
Personnel responsibility (P ₂)	8
Both P ₁ and P ₂	2
P ₃	0

CLASSIFICATION OF PRIMARY CAUSES OF DEATH:

HEMORRHAGE	7
Abortion, without sepsis	1
Afibrinogenemia	0
Abruptio	0
Am. fl. embolus	0
Dead fetus	0
Ruptured uterus	0
Atony, uterine, postpartum	2
Ectopic pregnancy without sepsis	3
Laceration, extrauterine	0
Placenta praevia	1
Retained placenta	0
Ruptured uterus (no afibrin.)	0
Other	0

(other causes and statistics available on request)

personnel responsibility!

We are surprised to find that **Eclampsia** caused death in five of the 38 patients; only **one** appeared in the last report (1976) and we were lulled into the hopeful illusion that we were conquering this age-old "killer," the etiology of which is not clear, today!

In a valiant effort to "screen out" "high risk OB patients," we still find that their extra-expert care is highly important; there were 13 high risk OB patients among the 38 that were studied. Of these, ten had a high risk factor related to the primary cause of death!

As a Committee we are pledged to continue the study of Ohio maternal

deaths. The ultimate value of preserving life and health among pregnant women and their newborns in Ohio is supported by a number of published observations in other states.^{4,5}

The OSMA Committee on Maternal and Neonatal Health is chaired by Edward Grable, M.D., Canton, Ohio.

The first such report was developed by Anthony Ruppertsberg, M.D., Columbus, Ohio.

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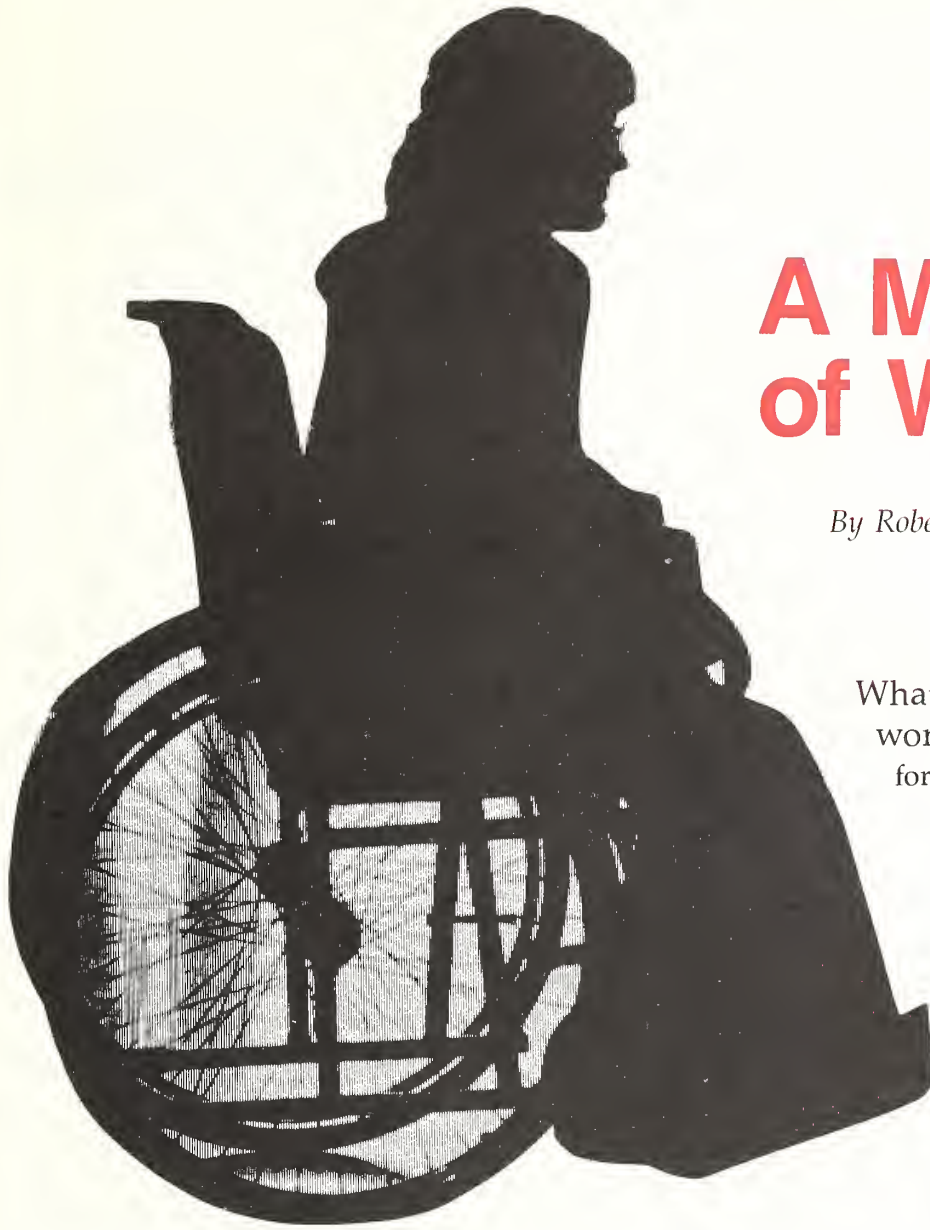
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A Matter of Worth

By Robert A. Dell

What are disabled workers worth . . . not just to their former employers, but to

themselves? Plenty. That's why legislation, enacted in the summer of 1979, authorized the Industrial Commission of Ohio to establish programs, designed to assist persons with work-related disabilities, return to work. By the end of the year, the Rehabilitation Division of the Industrial Commission was created.

The purpose of industrial rehabilitation is first, to move the disabled worker from a status of disability to that of gainful employment by providing the needed impetus and services. The return of the disabled employee to the work force not only leads to the patient's enhanced sense of self-esteem, but to the Commission's second, more economic purpose of reducing the costs of Workers' Compensation.

Ohio's Program

Implementation of any statewide program requires both a system and a network of professionals. The Rehabilitation Division currently has ten district offices, placed strategically about the state. From these offices, units of two or more persons, called



A comprehensive rehabilitation program draws upon a number of therapy modalities . . . physical medicine, nursing and reemployment counseling for example.

Disability Prevention Teams, seek out and contact prospective candidates for rehabilitation programs. Criteria for admission include the candidate's having (or having had) a valid Workers' Compensation claim, and having work-related disability, with a prognosis of favorable response to standard rehabilitation therapies. For the program to work, the candidate also must make a commitment to the program, must understand and agree with the goals, and must agree to attend all therapy sessions and cooperate.

Participation in the program is voluntary. Should the candidate for rehabilitation choose not to participate, or should he or she elect at any time to withdraw from the program, current law enables the candidate to return to the status of Workers' Compensation claimant, in accordance with Workers' Compensation law.

Disability Prevention Teams are built about a nucleus of rehabilitation consultant and registered nurse. Additional health-care professionals are enlisted as needed, dependent upon needs of the individual candidate for rehabilitation. A large majority of rehabilitation candidates are treated by physicians in private practice, and other private practitioners, situated in the claimant's home community or a nearby community. All bills for approved rehabilitation services are paid by the Bureau of Workers' Compensation. Physicians submit bills for their fee to the Rehabilitation Consultant who has engaged their services.

Comprehensive Rehabilitation

A comprehensive rehabilitation

program draws upon a number of therapy modalities, including physical medicine, nursing, occupational therapy, physical therapy, nutritional counseling, personal counseling, health education, pain reduction, work evaluation, and reemployment counseling. The majority of rehabilitation candidates require one to several of these services. A small percentage of candidates require the majority of these services. In such a case, it is most practical to invite the candidate to come to the Columbus Center, a comprehensive rehabilitation center, located at 106 North High Street, Columbus. At the "Columbus Center," all rehabilitation services are provided under one roof, by a licensed professional staff, thus relieving the claimant needing a number of therapies from going from place to place to obtain them. There is no cost for any therapy provided at the Columbus Center, cost being paid from the Workers' Compensation surplus fund.

The claimant attending a program at the Columbus Center is provided lodging and meals (if from out of town), and travel expenses are paid. Transportation is provided between accommodations and the Columbus Center. Families are encouraged to participate at times scheduled. Claimants are free to return to the home community on weekends.

Anyone participating in a rehabilitation program is paid living maintenance in lieu of Workers' Compensation. Living maintenance is always at least equal to, or in excess of the Workers' Compensation benefit.

There are basically two types of programs conducted at the Columbus

Center: general rehabilitation programs, which average six weeks in length; and pain and stress programs, usually three weeks in length. When programs are completed, whether in the Columbus Center or in the districts, reemployment specialists work with rehabilitated candidates to return them to active employment. There are incentives to employers to encourage engaging the rehabilitated person, as in those circumstances where the employee may take several weeks to gain proficiency. If modification of machinery or procedures is necessary, costs are defrayed by the Workers' Compensation surplus fund.

Unfortunately, not everyone can be rehabilitated. Some persons are so severely disabled that futility of engaging them in rehabilitation programs is apparent. In other cases, persons showing favorable prognosis for rehabilitation may in finality not respond to therapies, and they may have to return to Workers' Compensation status.

In the Interest of the Physician

We have been asked in the Rehabilitation Division, rather often, what we have to offer at the Columbus Center that cannot be offered by private practitioners in the claimant's home community. In actuality, we are **not** miracle workers, and we have no secret therapies. We recognize that the physician in private or group practice, together with other health-care practitioners in the claimant's community, can provide the same therapies we offer, and at the same level of competency. The selling point of our Columbus Center program is

continued on page 821



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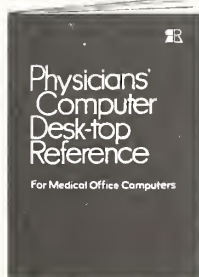
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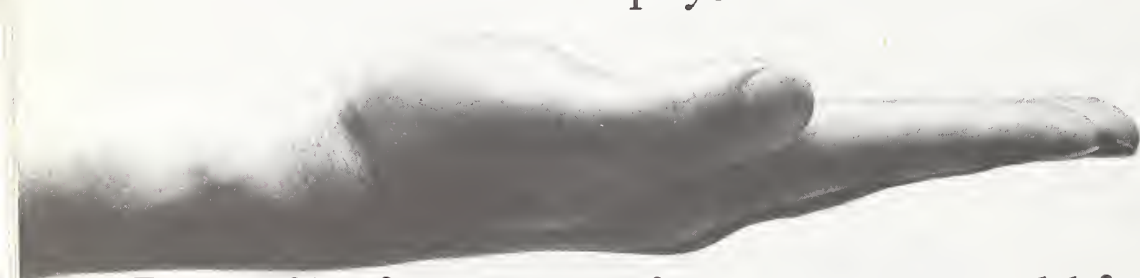
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It is hoped that physicians will recognize the Rehabilitation Division as a resource they can utilize to advantage, and that they will see us as an adjunct to their practices.

that we can offer attention to any claimant 40 hours per week, which is a level of concentration impractical to the physician having many patients in his or her practice. Whereas the small percentage of patients invited to come to the Columbus Center may be out of the physician's immediate practice for several weeks, almost all persons completing rehabilitation programs return to the home community. It is hoped, thus, that physicians throughout the state will recognize in the Rehabilitation Division a resource they can utilize to advantage, and that they will see us as an adjunct to their practices.

The key to the success of Ohio's Industrial Rehabilitation Program is the referral process. We learn of persons in need of rehabilitation services through several sources, commencing with the Ohio Bureau of Workers' Compensation. In addition, referrals are made by employers, unions, the claimant's family, and especially by physicians. To make a referral, the physician may write to the address given earlier, or he or she may call us at our statewide, toll-free number: 1-800-282-0817. When making a referral, it is very helpful to provide standard statistical information about the claimant — especially the Workers' Compensation claim number.

The Future

The Columbus Center is in itself an impressive venture, with a capacity of 45 patients at any time. However, it is only a prelude of things to come. Two major, comprehensive rehabilitation centers have been committed for the state, one to be in Columbus and one to be in Cleveland. The major center in Columbus, already under construction at 2050 Kenny Road, will

accommodate 375 patients at any time. Projected to be more advanced than any other center on the North American continent, it is scheduled to commence operation in December of 1983. The Cleveland Center, with a capacity of 425 patients, is projected to commence operation in 1985.

An Invitation

The Rehabilitation Division would like for the medical community to become better acquainted with what we are doing at the Columbus Center, at 106 North High Street in the capitol

city. Tours can be arranged, preferably to small groups, the best time being on Friday afternoons after 2:30 p.m. It is best to call in advance to make arrangements, so that we can be prepared for your group when you come. To arrange for a tour, please call the Public Relations Department, at (614) 466-5538.

Robert A. Dell has a background in industry, medical writing and editing, as well as Ohio's Workers' Compensation program. He currently is Chief of Public Relations of the Rehabilitation Division of the Industrial Commission of Ohio.

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Health Care Costs and the American Lifestyle:

Views of the Professional

By A. Kristina Burkhart, J.D., and Craig G. Burkhart, M.D.

A national fervor for better health is present. Americans are assuming a greater responsibility for their own health and are demanding more education concerning improving their lifestyles. Self health care is a desired commodity. In this presentation, the American lifestyle will be assessed in consort with the results of a questionnaire survey sent to 216 professionals in accounting, engineering, law, and medicine.¹ The results from the survey are italicized in the text.

The American lifestyle has become another recognized factor of rising health care costs. While many diseases have been conquered, and while public expenditures for health have nearly doubled since 1970, death rates and life expectancies have changed little over the last 30 years. The death rate for heart disease was 355.5/100,000 in 1950, and was 353.1/100,000 in 1975. Progress has been stagnate to some degree by Americans' lifestyle of smoking, alcohol, fatty foods, obesity, lack of exercise and carelessness on the highway.

Regular exercise is now emphatically endorsed by the President's Council

on Physical Fitness and Sports as a preventive health measure to guard against disease, and the economic consequences of disease (ie, absenteeism, premature death, sick pay, and increased health care spending). Many private firms have become committed to employee fitness with more than 300 companies employing full-time fitness directors by 1975.²

The typical job in a modern office or automated factory requires less physical exertion than a hot shower . . .

Why the major emphasis on exercise? To begin with, the work environment has changed.

"The typical job in a modern office or automated factory requires less physical exertion than a hot shower.

The predictable consequence: degeneration of various bodily systems, especially the muscular, respiratory and cardiovascular system.³

Combine physical inactivity with cigarette smoking and nearly one half of all premature deaths in the United States can be accounted for.³

Health hazards such as alcohol, smoking, or drug abuse are generally known to most. "Diet" also can lead to health problems. Poor eating habits can be associated with obesity, malnutrition, and increased risk of such diseases as heart attacks and bowel cancer.^{4,5} A U.S. Department of Agriculture study suggests one half of health-care costs can be eliminated by improving nutrition. Thus, when physical inactivity is combined with other factors such as smoking, alcohol abuse, or poor diet, the risk of serious illness, such as coronary heart disease, increases.⁶

What has been recommended? The California Chamber of Commerce has completed its first phase of a campaign to get business involved in a drive to ensure cost-effective medical care. Its document "Employer Health Care

Health care costs and the Americans

As a total group, professionals believe too many Americans drink too much . . . However, engineers and accountants were not sure that Americans drink to excess, while physicians and attorneys were inclined to believe they did . . .

Costs Savings Techniques" (June 1980) urges employers to remind employees to follow the following rules.

1. Get seven to eight hours of sleep each day.
2. Eat breakfast regularly.
3. Stay slender (slightly below normal weight).
4. Seldom snack between meals.
5. Stay active with planned exercise, sports, walking, or vigorous work.
6. Use alcohol moderately, if at all.
7. Don't smoke.

The professionals (accountants, physicians, lawyers, and engineers) that participated in the survey concerning lifestyles agreed that Americans' lifestyles contribute to health care costs. Even more emphatically, they felt most Americans could improve their lifestyles and become healthier. Response for each group were skewed toward agreeing that too many Americans:

- don't exercise enough
- are generally 10% overweight
- smoke
- consume too much nonnutritious foods
- do not adequately attempt to control or test for high blood pressure

As a total group, professionals tended to believe too many Americans drink too much. When each professional group is examined, engineers and accountants were not sure whether too many Americans drink excessively. Physicians and lawyers were more inclined to agree that too many Americans drink excessively.

Accountants and physicians tended to disagree that at least seven hours of sleep is necessary. Lawyers tended to agree that everyone should consistently get at least seven hours of sleep. Engineers were basically split into equal parts on this question. The sum of all professional group responses showed 31% were not sure, 37% disagreed, and 32% agreed.

How stress is handled also affects health. Often it is discussed in terms

of Type A and Type B behavior. Type A behavior is characterized by enhanced aggressiveness and competitive drive, preoccupation with deadlines, chronic impatience, and a sense of time urgency, in contrast with the more relaxed and less hurried Type B behavior pattern.⁵ Type A personalities have been found to have more elevated levels of the various risk factors of coronary heart disease than Type B personalities.

Type A personalities have also been found to be associated with a higher risk of coronary heart disease. Other researchers have found stress may be implicated in up to 80% of all illnesses.⁷ Stress-related illnesses include ulcers, migraines, and asthma as well as coronary heart disease. Both managers and individuals need to be aware of signs of stress and of methods of relieving stress in those instances which it cannot be prevented, for stress relief often depends upon support systems rather than individual effort of self-awareness and coping.

CPAs, engineers and lawyers tend to believe that most people do not adequately deal with stress. Physicians were more unsure whether most people deal adequately with stress as 50% answered not sure. For the professional sample population as a whole, the majority agreed that most people do not adequately deal with stress (67%). However, a large number answered "not sure" (28%).

Health care costs as a percentage of GNP have risen from 4.5% in 1955 to 5.9% in 1965, to 8.4% in 1975 to 10-12% in the 1980s. Various studies have been made of the economic costs of illness. Basically there are two costs generally considered — direct and indirect.

Direct Costs - outlays for prevention, detection and treatment of illness.

Indirect Costs - loss in output due to (a) morbidity, or disability, and (b)

estyle: Views of the Professional

mortality, or premature death.

Another cost has been mentioned, but has not been quantified — the cost of pain and suffering.

Circulatory diseases account for approximately 50% of all deaths by diagnosis and 16.8% of the estimated person-years lost to productivity. The second highest organ disease causing lost productivity is respiratory illnesses.

The economic cost of alcohol abuse has been estimated to have been \$31.4 billion. Of this \$31.4 billion, lost production cost was estimated to have been more than \$14.8 billion, and health-care costs almost \$8.3 billion. Excess mortality due to alcohol abuse was estimated to account for almost 7% of all male deaths. There are an estimated 4.7 million families with problem drinking men and 9 million alcoholics in the U.S. today.

Recently, the cost of smoking was estimated to be \$27.5 billion with \$8.2 billion direct costs and \$19.3 billion indirect costs.⁸ Annual lost wages due to cigarette-related illnesses have been estimated to be about \$3 billion. Close to 300,000 premature deaths annually can be related to cigarette smoking.

Health of workers affects industry. Premature deaths cost industry more than \$25 billion and 132 million lost workdays of production each year. The American Heart Association estimates recruiting replacements for executives who died of heart attacks cost industry \$700 million annually. Prosaic backache, often due to neglected muscles, is responsible for \$1 billion in lost output and \$0.25 billion in workmen's compensation claims. What are some of the costs that industry assumes due to smoking and alcoholism?

Alcoholism - alcoholic employees are absent 2.5 times as often and have 3.6 times as many accidents. \$15.6 billion annually are lost due to absenteeism and medical costs.

Smoking - 77 million work days are

lost each year; increased maintenance costs due to wastes, fumes and films; mental efficiency of the employee is diminished.

Poor health also results in inefficiencies, increased risk of accidents, and decreased productivity, as well as absenteeism and terminations due to premature deaths.

Disease and poor fitness also are directly tied to the rising cost of health insurance for which industry pays a huge portion. General Motors now spends more on its employers' health plan than it spends on purchasing steel from its principal supplier. The cost is passed to the consumer, be it an individual or business. For example, \$175 of health plan benefits go into the price of each car and truck manufactured by General Motors. In 1977, the U.S. businesses paid 25% of the national \$161 billion health bill — a cost indirectly paid by the consumer.

In the survey, all groups strongly correlated employee health with productivity and efficiency. The majority also agreed that the image of a firm and the loyalty of its employees were augmented with improved employee health. There was considerable uncertainty as to whether employee-initiated terminations of employment would decrease if health styles were improved. The most common response was not sure of its effect. Of these professions that voiced an opinion, lawyers and physicians tended to agree that employee terminations of employment would decrease while accountants and engineers tended to disagree.

Craig G. Burkhardt, M.D., is Head of Dermatology, at the Medical College of Ohio at Toledo. His wife, A. Kristina, holds a CPA and MBA in addition to her degree in law.

(Please see related story on page 831)

All groups strongly correlated employee health with productivity and efficiency . . . and agreed that the image of a firm, the loyalty of its employees were augmented with improved employee health.

HYPERTENSION:



METHYLDOPA? RESERPINE? INDERAL? COUNTLESS THOUSANDS WOULD BE BETTER OFF WITH

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INDERAL exhibits few of the disturbing side effects of methyldopa and reserpine. Sedation, depression, and impotence are rare.* Tolerance is not likely to occur, as it frequently does with methyldopa. For the vast majority of patients—INDERAL means a step toward improving the quality of life. (INDERAL should not be used in the presence of congestive heart failure, sinus bradycardia, heart block greater than first degree, and bronchial asthma.)*

INDERAL blocks beta-receptor sites *in the heart* to reduce heart rate and cardiac output—reducing cardiac work load—sparing an overburdened heart.

Hypertensive hearts can rest easy with INDERAL. For many—it is ideal, first-step therapy.

INDERAL—the sooner, the better for hypertension—a leading risk factor in coronary heart disease.¹

INDERAL[®]

(PROPRANOLOL HCl) B.I.D.

The sooner, the better.



*Please see following page for Brief Summary of Prescribing Information.

THE MOST WIDELY PRESCRIBED BETA BLOCKER IN THE WORLD

INDERAL® (PROPRANOLOL HCl) B.I.D. FOR HYPERTENSION



BRIEF SUMMARY (FOR FULL PRESCRIBING INFORMATION, SEE PACKAGE CIRCULAR)
Inderal® (propranolol hydrochloride)

BEFORE USING Inderal (PROPRANOLOL HYDROCHLORIDE), THE PHYSICIAN SHOULD BE THOROUGHLY FAMILIAR WITH THE BASIC CONCEPT OF ADRENERGIC RECEPTORS (ALPHA AND BETA), AND THE PHARMACOLOGY OF THIS DRUG

CONTRAINDICATIONS

1) bronchial asthma, 2) allergic rhinitis during the pollen season, 3) sinus bradycardia and greater than first degree block, 4) cardiogenic shock, 5) right ventricular failure secondary to pulmonary hypertension, 6) congestive heart failure (see WARNINGS) unless it is secondary to a tachyarrhythmia treatable with propranolol; 7) in patients on adrenergic-augmenting psychotropic drugs (including MAO inhibitors), and during the two week withdrawal period from such drugs

WARNINGS

CARDIAC FAILURE. In congestive heart failure, inhibition with beta-blockade carries the potential hazard of further depressing myocardial contractility and precipitating cardiac failure. In patients already receiving digitalis, propranolol may reduce the positive inotropic action of digitalis and may have an additive depressant effect on AV conduction.

IN PATIENTS WITHOUT A HISTORY OF CARDIAC FAILURE, in rare instances, cardiac failure has developed during propranolol therapy. At the first sign of impending cardiac failure, patients should be fully digitalized and/or given a diuretic, and observed closely. a) If cardiac failure continues, despite adequate digitalization and diuretic therapy, propranolol should be immediately withdrawn, b) If tachyarrhythmia is being controlled, patients should be maintained on combined therapy and closely followed until threat of cardiac failure is over.

IN PATIENTS WITH ANGINA PECTORIS, there have been reports of exacerbation of angina and, in some cases, myocardial infarction, following abrupt discontinuation of Inderal therapy. Therefore, when discontinuance of Inderal is planned the dosage should be gradually reduced and the patient carefully monitored. In addition, when Inderal is prescribed for angina pectoris, the patient should be cautioned against interruption or cessation of therapy without the physician's advice. If Inderal therapy is interrupted and exacerbation of angina occurs, it is usually advisable to reinstitute Inderal therapy and take other measures appropriate for the management of unstable angina pectoris. Since coronary artery disease may be unrecognized, it may be prudent to follow the above advice in patients considered at risk of having occult atherosclerotic heart disease, who are given propranolol for other indications.

IN PATIENTS WITH THYROTOXICOSIS, possible deleterious effects from long term use have not been adequately appraised. Give special consideration to propranolol's potential for aggravating congestive heart failure. Propranolol may mask the clinical signs of developing or continuing hyperthyroidism or complications and give a false impression of improvement. Propranolol should be withdrawn slowly, since abrupt withdrawal may be followed by an exacerbation of symptoms of hyperthyroidism, including thyroid storm. Propranolol does not distort thyroid function tests.

IN PATIENTS WITH WOLFF-PARKINSON-WHITE SYNDROME, several cases have been reported in which, after propranolol, the tachycardia was replaced by a severe bradycardia requiring a demand pacemaker. In one case this resulted after an initial dose of 5 mg propranolol.

IN PATIENTS UNDERGOING MAJOR SURGERY, beta-blockade impairs the ability of the heart to respond to reflex stimuli. Except in pheochromocytoma, propranolol should be withdrawn 48 hours prior to surgery. In case of emergency surgery, the effects of propranolol can be reversed by administration of beta-receptor agonists such as isoproterenol or levaterenol, but such patients may be subject to protracted severe hypotension. Difficulty in restarting and maintaining the heart beat has been reported.

IN PATIENTS PRONE TO NONALLERGIC BRONCHOSPASM (e.g., CHRONIC BRONCHITIS, EMPHYSEMA), administer with caution, since propranolol may block bronchodilation produced by endogenous and exogenous catecholamine stimulation of beta-receptors.

DIABETICS AND PATIENTS SUBJECT TO HYPOGLYCEMIA. Propranolol may prevent the appearance of premonitory signs and symptoms (pulse rate and pressure changes) of acute hypoglycemia, especially in patients with labile diabetes. A precipitous elevation of blood pressure may accompany hypoglycemic attacks.

USE IN PREGNANCY. Safe use in human pregnancy not established. Embryotoxic effects have been seen in animals at doses about 10 times the maximum recommended human dose.

PRECAUTIONS

Patients receiving catecholamine depleting drugs such as reserpine should be closely observed if propranolol is administered, since it may occasionally produce hypotension and/or marked bradycardia resulting in vertigo, syncope attacks, or orthostatic hypotension.

Observe laboratory parameters at regular intervals. Use with caution in patients with impaired renal or hepatic function.

ADVERSE REACTIONS

Cardiovascular: bradycardia, congestive heart failure, intensification of AV block, hypotension, paresthesia of hands, arterial insufficiency, usually of the Raynaud type, thrombocytopenic purpura. **Central Nervous System:** lightheadedness, mental depression manifested by insomnia, lassitude, weakness, fatigue, reversible mental depression progressing to catatonia; visual disturbances, hallucinations, an acute reversible syndrome characterized by disorientation for time and place, short term memory loss, emotional lability, slightly clouded sensorium, and decreased performance on neuropsychometrics. **Gastrointestinal:** nausea, vomiting, epigastric distress, abdominal cramping, diarrhea, constipation, mesenteric arterial thrombosis, ischemic colitis. **Allergic:** pharyngitis and agranulocytosis, erythematous rash, fever combined with aching and sore throat, laryngospasm and respiratory distress. **Respiratory:** bronchospasm. **Hematologic:** agranulocytosis, nonthrombocytopenic purpura, thrombocytopenic purpura. **Miscellaneous:** reversible alopecia. Oculomucocutaneous reactions involving the skin, serous membranes and conjunctivae reported for a beta-blocker (practolol) have not been conclusively associated with propranolol. **Clinical Laboratory Test Findings:** Elevated blood urea levels in patients with severe heart disease, elevated serum transaminase, alkaline phosphatase, lactate dehydrogenase.

HOW SUPPLIED

TABLETS

—Each hexagonal-shaped, orange, scored tablet is embossed with an "I" and imprinted with "INDERAL 10," contains 10 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0421-81) and 1,000 (NDC 0046-0421-91). Also in unit dose package of 100 (NDC 0046-0421-99).

—Each hexagonal-shaped, blue, scored tablet is embossed with an "I" and imprinted with "INDERAL 20," contains 20 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0422-81) and 1,000 (NDC 0046-0422-91). Also in unit dose package of 100 (NDC 0046-0422-99).

—Each hexagonal-shaped, green, scored tablet is embossed with an "I" and imprinted with "INDERAL 40," contains 40 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0424-81) and 1,000 (NDC 0046-0424-91). Also in unit dose package of 100 (NDC 0046-0424-99).

—Each hexagonal-shaped, yellow, scored tablet is embossed with an "I" and imprinted with "INDERAL 80," contains 80 mg propranolol hydrochloride, in bottles of 100 (NDC 0046-0428-81) and 1,000 (NDC 0046-0428-91). Also in unit dose package of 100 (NDC 0046-0428-99).

The appearance of these tablets is a trademark of Ayerst Laboratories.

Store at room temperature (approximately 25° C).

INJECTABLE

—Each ml contains 1 mg of propranolol hydrochloride in Water for Injection. The pH is adjusted with citric acid. Supplied as 1 ml ampuls in boxes of 10 (NDC 0046-3265-10).

Store at room temperature (approximately 25° C).

7997/882

Reference: 1 Freis, E.D. Hypertension (Suppl. II) 3:230 (Nov-Dec) 1981

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Attitudes toward Health:

A Professional's Perspective

By A. Kristina Burkhart, J.D., and Craig G. Burkhart, M.D.

A questionnaire on attitudes toward health was sent to the following group of professionals: certified public accountants (CPAs), engineers, lawyers, and physicians. The purpose was to explore professional attitudes concerning five primary areas of health care, namely:

1. General feelings about national health care costs.
2. Employer responsibility for employee health styles.
3. General feelings about professional environment, with an emphasis on stress perceptions.
4. Perceptions of the professional about his/her own firm's environment.
5. What the professional's firm does in terms of improving present lifestyles.

This article will explore the first and the last attitudes mentioned.

The survey was sent to 216 professionals picked systematically from the yellow pages of the Toledo and vicinity phone book. The following return rates were achieved:

The survey offered no monetary incentive with no secondary mailing. It was reviewed and supported by the President and Dean of the Medical College of Ohio at Toledo, as well as the executive committee of the Toledo Academy of Medicine, as was clearly delineated in the cover letter.

The results of this survey will be used to supplement a review of particular issues in the health care industry. The first subject assessed is health care costs.

In November of 1977, the American Medical Association, the American Hospital Association and the Federation of American Hospitals

developed the Voluntary Effort (VE) to decrease the rate of escalating health care costs. VE now includes physicians, hospitals, suppliers, insurance carriers, businesses and consumers. Organized at the local, state and national levels, the VE is directed toward private sector control of hospital and health care costs as opposed to government cost regulation of the health care industry.

All of the physicians responding to the survey were aware of VE, whereas less than half of the other professionals were aware of its existence.

Awareness is growing that the costs of medical care are not due solely to physicians and hospitals, but to a number of factors.

Awareness is growing that the costs of medical care are not due solely to physicians' and hospitals' charges, but to a myriad of factors. The VE has been effective in decreasing the rate of increase, nevertheless, the Hospital Expense indicator continues to rise.

The two major factors predicted by the American Hospital Association to cause the 1979-1980 increase in expenses were: 1) inflation, and 2) rapidly rising utilization. For comparative evaluation in recent years the Consumer Price Index rose from 10.9% for June 1978-1979, to 14.3% for

June 1979-1980. The underlying rate of inflation (which excludes energy, housing and transportation which rose dramatically, as well as other elements) rose from 7.1% to 9.6% during the same time period. Comparison of June 1979 to June 1980, shows medical care prices rose from 9.1% to 11.4%. Hospital and other medical care services rose from 10.8% to 13.1%, and hospital room rates rose from 11.8% to 12.7%. All of these rates are below the Consumer Price Index rate increase, yet hospitals felt inflationary pressures as well, which were reflected in its own performance indicators.

Inflation increased growth rates of both the hospital labor component (wages), and nonlabor component (supplies). Nonlabor expenses rose from 12.2% for the June 1978-1979 period, to 15.8% for the June 1979-1980 period. Labor expenses rose from 13.5% to 14.9%. If inflation had remained at the June 1979 rate, the rate of increase for inpatient hospital expenses would have been 12.3% instead of 15.3%.

While inflation added to total costs and the rate increases, so did a rapid utilization growth. Admissions increased 5.5% between June 1979 and June 1980 (same month previous year comparisons). Occupancy rates in 1980 were of the highest levels since 1974.

Technology also adds to costs, yet technology also benefits by increasing life spans. Two problem areas arise with technology: 1) development, start-up, and obsolescence costs, and 2) locality problems. How are new methods of care, new machines and new inventions assessed? To some

extent effective technological assessment, like regional planning, runs head-on into local price, local autonomy, and local initiative.

Each autonomous unit would prefer its own dialysis machines, neonatal intensive care unit, and organ transplant centers. The locality wants its "own" even if utilization is low and therefore costs per utilization high, rather than share a technological advance with other locale.

Another area of concern is the increasing aging population. The geriatric population is of course beset with comparably more health problems. With this increased frequency of medical problems, proper health care service utilization is required. Perhaps the impact of health costs is not as much growth in total number, but growth in components of the total.

In the survey, all professional groups agreed that inflation substantially contributed to the

increase in health care costs. Technology also was considered a major factor by all groups. Whereas physicians and accountants believed other substantial factors increasing health care costs were the quality of care demanded and the increased demand for services, lawyers and engineers disagreed.

The corollary to a previous question was asked, specifically can health care costs be significantly reduced by decreasing demand for services. While CPAs felt that increased demand for service increased costs of health care, they answered that **decreasing** demand would not substantially decrease costs. Lawyers were split on whether increased demand increased costs, however, they seem to feel that decreasing demand would not significantly reduce costs. Physicians still are skewed toward agreement as to a relationship between costs of health care and demand for services.

Another area of concern is the increasing aging population. Perhaps the impact of health costs is not as much growth in total number but growth in components of the total.

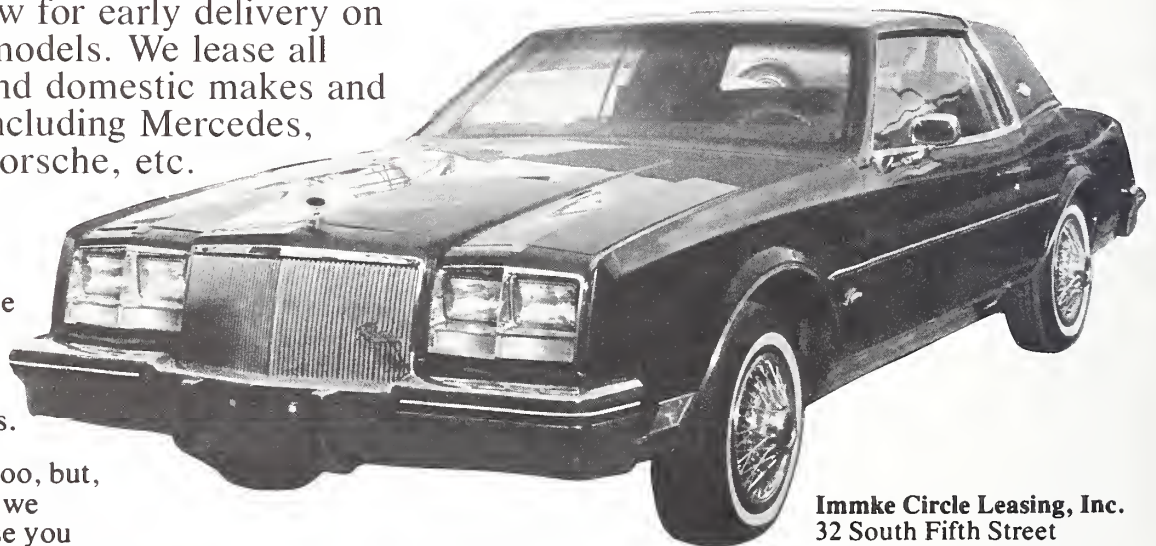
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Each tablet contains acetaminophen and codeine phosphate* as follows:
No. 2—acetaminophen, 325 mg and codeine phosphate*, 15 mg (1/4 gr)
No. 3—acetaminophen, 300 mg and codeine phosphate*, 30 mg (1/2 gr)
No. 4—acetaminophen, 300 mg and codeine phosphate*, 60 mg (1 gr)

*WARNING: May be habit forming

Please see adjacent page for brief summary of prescribing information.

TABLETS
ANACIN-3®
ACETAMINOPHEN
with Codeine

Brief Summary (For full prescribing information see package insert.)

Description: Each Tablet Contains

Acetaminophen 325 mg. and Codeine Phosphate*, 15 mg

Acetaminophen 300 mg. and Codeine Phosphate*, 30 mg

Acetaminophen 300 mg. and Codeine Phosphate*, 60 mg

*WARNING: May be habit forming

Contraindications: Hypersensitivity to acetaminophen or codeine.

Warnings: Drug Dependence: Codeine can produce drug dependence of the morphine type, and may be abused. Dependence and tolerance may develop upon repeated administration. Prescribe and administer with the same degree of caution appropriate to the use of other oral narcotic medications. Subject to the Federal Controlled Substances Act (Schedule III).

Precautions: Head injury and increased intracranial pressure: The respiratory depressant effects of narcotics and their capacity to elevate cerebrospinal fluid pressure may be markedly exaggerated in the presence of head injury, other intracranial lesions or a preexisting increase in intracranial pressure. Narcotics produce adverse reactions which may obscure the clinical course of patients with head injuries.

Acute abdominal conditions: Codeine or other narcotics may obscure the diagnosis or clinical course in patients with acute abdominal conditions.

Special risk patients: Administer with caution to certain patients such as the elderly or debilitated, and those with severe impairment of hepatic or renal function, hypothyroidism, Addison's disease, and prostatic hypertrophy or urethral stricture.

Information for Patients: Codeine may impair the mental and/or physical abilities required for the performance of potentially hazardous tasks such as driving a car or operating machinery. The patient taking this drug should be cautioned accordingly.

Drug-Interactions: Patients receiving other narcotic analgesics, antipsychotics, anti-anxiety, or other CNS depressants (including alcohol) concomitantly with acetaminophen and codeine may exhibit additive CNS depression due to the codeine component. When such therapy is contemplated, the dose of one or both agents should be reduced.

The use of MAO inhibitors or tricyclic antidepressants with codeine preparations may increase the effect of either the antidepressant or codeine.

The concurrent use of anticholinergics with codeine may produce paralytic ileus.

Usage in Pregnancy: Safe use in pregnancy has not been established relative to possible adverse effects on fetal development. Therefore, acetaminophen and codeine should not be used in pregnant women unless, in the judgment of the physician, the potential benefits outweigh the possible hazards.

Nursing Mothers: It is not known whether the components of this drug are excreted in human milk. Because many drugs are excreted in human milk, caution should be exercised when acetaminophen and codeine are administered to a nursing woman.

Adverse Reactions: Most frequently: Lightheadedness, dizziness, sedation, shortness of breath, nausea and vomiting. More prominent in ambulatory than in non-ambulatory patients, and some of these adverse reactions may be alleviated if the patient lies down. Others: Euphoria, dysphoria, constipation and pruritus.

Dosage and Administration: Dosage should be adjusted according to severity of pain and response of the patient. However, it should be kept in mind that tolerance to codeine can develop with continued use and that the incidence of untoward effects is dose related. This product is inappropriate even in high doses for severe or intractable pain. Adult doses of codeine higher than 60 mg fail to give commensurate relief of pain but merely prolong analgesia and are associated with an appreciably increased incidence of undesirable side effects. Equivalently high doses in children would have similar effects.

Adults: **Codeine**—15-30 mg (for mild to moderate pain)

60 mg (for moderate to moderately severe pain)

Acetaminophen—300-600 mg

Children: **Codeine**—500 mcg/kg

Doses can be repeated up to every 4 hours.

Full directions for use should be consulted prior to administering or prescribing.

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Rx
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Medical Crossword

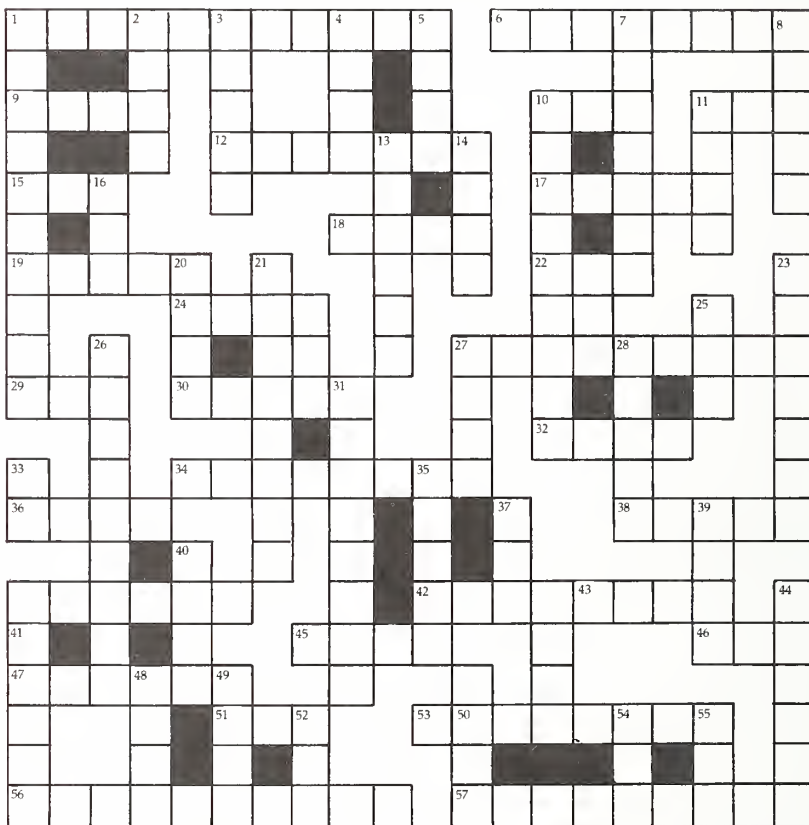
By R. M. Benson, M.D.

OBESITY

ACROSS: 1. Syndrome of obesity, mental retardation, hypogonadism, hypotonia, and small feet, 6. food energy equivalent, 9. Cleveland's lake, 10. even score, 11. (Abbrev.) prepaid health care system, 12. organ source of cortisol, 15. male parent, 17. give up, 18. earth's satellite, 19. homo sapien, 22. not in, 24. black, 27. fat cell, 29. oxygen prefix, 30. palm fruits, 32. wicked, 34. syndrome due to excess of twenty-one down, 36. Russian gymnast, 38. this bird gets the worm, 41. method, 42. bone age in obese children, 45. Las Vegas machine, 46. Von Gierkes missing glucose phosphatase, 47. in the thyroid it's hot or cold, 51. cask, 53. urine seventeen keto ____, 56. feature of (menstrual) Stein Leventhal syndrome, 57. see thirty-one down.

DOWN: 1. parathyroidism with obesity, short stature and resistance to PTH, 2. obesity therapy, 3. plane detecting device, 4. green citrus fruit, 5. Hawkeye state, 7. major cause of obesity, 8. stature of patients with endocrine obesity, 10. major thyroid hormone, 11. ____ and go seek, 13. syndrome of Turner's phenotype with normal karyotype, 14. the ____ ranger, 16. faint light, 20. require, 21. major glucocorticoid, 23. excess fat, 25. optic organ, 26. part of one across and Kallmans syndrome, 27. pub brews, 28. martini garnish, 31. with fifty-seven across quantitates obese state in skin, 33. Turner karyotype, 35. this puzzle and a Santini, 37. (Abbrev.) Thanksgiving month, 39. Cincinnati baseball team, 40. basic tissue unit, 41. a hypo from one across and one down, 43. affirm, 44. too much, 48. once ____ a time, 49. always, 50. immediate order, 52. pituitary hormone elevated in hypothyroidism, 54. writing fluid, 55. observe.

See answers next month.



Dr. Benson is the Director of
Pediatric Endocrinology at
Children's Hospital
Medical Center, Akron.

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6/81



Solving the Paper Chase

By Karen S. Edwards

You can't live with them. . . you can't live without them.

Despite their cold, impersonal image and their reputation as being too technological, computers can be, and often are, worth their weight in microchips when they are properly understood and utilized.

This past September, the Ohio State Medical Association installed its new computer, a Data General C-350. Its arrival at the OSMA was by no means brash or sudden. It was an arrival that was nearly six years in the making.

"When we first decided to computerize our membership records, we contracted computer time from a Service Bureau," says Katherine Wisse, OSMA's Associate Executive Director and Comptroller of Membership and Finance.

But being at the mercy of someone else's timetable proved to be awkward and coupled with a limited usage versatility, it became more and more obvious that an in-house computer was in order. Data General's CS-40 computer was ordered, and it met expectations — but activities at the Association have, in the meantime, become more complex. The demands on the CS-40 exceeded its capacity to deliver and the decision to progress to the C-350 was made.

"As an example of the improved capability of the new machine, the C-350 can sort address labels in one tenth the time it took the CS-40, and still perform other functions

simultaneously," explains Joe Dusina, OSMA's manager of data processing. The CS-40 was incapable of doing anything else while labels were being sorted, and that meant costly "down" time — time the computer could not be used for other tasks.

The new computer, however, can not only handle all of the tasks performed by the CS-40 (both faster, and more efficiently) but has additional application capabilities which were not possible on the old machine.

"Word processing and telecommunications are both areas in which the new computer can take us when those needs arise," says Dusina, and last month the OSMA began taking steps toward adding word processing capabilities.

However, as Wisse points out, the machine is well-utilized now by a number of departments.

"Membership dues billing, processing, and keeping track of members is done by the computer; biographical information on each member is kept on file; the computer produces all mailing labels; does CME record keeping, Journal billing, certification of dues to the AMA; it provides an accurate membership count, which is important for the House of Delegates verification; and processes all of the Association's accounting functions," Wisse says. "It is also a vital tool for membership recruitment."

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Solving the paper chase

continued

In addition, the computer recently has been used for some special projects.

"The results of the readership survey, conducted by the Communications Department this past spring, was compiled and tabulated by computer, so the staff could see exactly what members needed or wanted from their publications and respond to those needs," Dusina says.

The computer also is used by the Legislative Department in their "key physician" program.

The program, now two years old, was developed by Eric Burkland, OSMA's Associate Director, Department of State Legislation, and has proven to be so effective that it has been copied by other state associations.

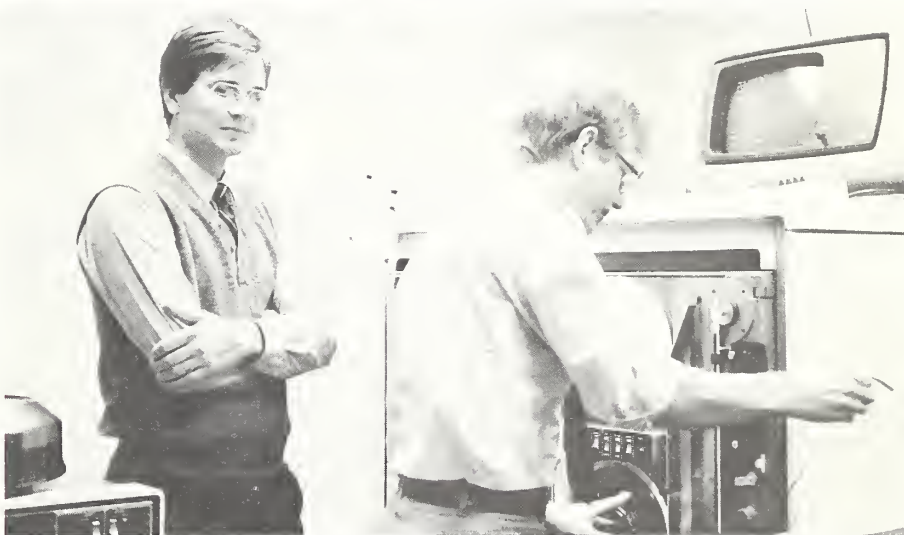
The Legislative Department can turn to the computer when they want to send an "alert."

To implement this program, physician members were sent a questionnaire, asking which political issues they were interested in, and their legislative contacts — politically, socially, or as physicians. This information then was compiled and tabulated, giving the Legislative staff the names and interests of those members who wanted to be politically active, and their relationship with the state legislators.

Now, when a controversial bill affecting the practice of medicine is scheduled for a committee hearing, the Legislative Department can turn to the computer and extract a list of physicians who are interested in that subject and have an "alert" letter sent to them that same day. They also can enter into the computer the names of the legislators scheduled to hear the bill, and find out if there are any members who know these legislators. Those physicians then are contacted and urged to get in touch with those legislators.



Left: OSMA Comptroller Katherine Wisse, and the new C-350.



Bottom: Joe Dusina, left, manager of data processing, watches as operator Brian Bruckelmeyer changes tapes.

A similar program also has been set up using members of the OSMA Auxiliary.

Since so much work is being done on the new computer, another advantage the C-350 offers over its predecessor is its increased usage capability. Terminals, of course, are means of access to computers. The CS-40 was physically limited to nine terminals, but the practical limit of the C-350 as it is presently configured, is 20 to 24.

Of course, all of this means that a great amount of important information is being stored by the computer. . . and that means a lot of reliability on a technical instrument. How safe is that trust?

According to Dusina, it's very safe. But as an extra precaution, a tape is run daily of all the information stored on the computer as a back-up, in case electrical storms, technical failures, or acts of God damage vital portions of the data base.

Computers are no longer the wave of the future. They are the present, and no matter what press they may have received in the past, they have become as much a part of American business lifestyle as calculators and the business lunch.

OSMA's subsidiary company, The Physicians Administration Corporation of Ohio (PACO), now offers Ohio physicians a complete computer

continued on page 837

An added complication... in the treatment of bacterial bronchitis*



Brief Summary.
Consult the package literature for prescribing information.

Indications and Usage: Cefaclor (cefactor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms.

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae* (*Diplococcus pneumoniae*), *Haemophilus influenzae*, and *S. pyogenes* (group A beta-hemolytic streptococci).

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Cefaclor.

Contraindications: Cefaclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics.

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY. THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS. AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES. Antibiotics, including Cefaclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs.

Precautions: If an allergic reaction to cefaclor occurs, the drug should be discontinued, and if necessary the patient should be treated with appropriate agents, e.g., pressor amines, antihistamines, or corticosteroids.

Prolonged use of cefaclor may result in the overgrowth of nonsusceptible organisms. Careful observation of the patient is essential. If superinfection occurs during therapy, appropriate measures should be taken.

Positive direct Coombs tests have been reported during treatment with the cephalosporin antibiotics in hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition. It should be recognized that a positive Coombs test may be due to the drug.

Cefaclor should be administered with caution in the presence of markedly impaired renal function. Under such a condition, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended.

As a result of administration of Cefaclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinistest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Usage in Pregnancy—Although no teratogenic or antifertility effects were seen in reproduction studies in mice and rats receiving up to 12 times the maximum human dose or in fetuses given three times the maximum human dose, the safety of this drug for use in human pregnancy has not been established. The benefits of the drug in pregnant women should be weighed against a possible risk to the fetus.

Usage in Infancy—Safety of this product for use in infants less than one month of age has not been established.

Adverse Reactions: Adverse effects considered related to cefaclor therapy are uncommon and are listed below.

Gastrointestinal symptoms occur in about 2.5 percent of patients and include diarrhea (1 in 70) and nausea and vomiting (1 in 50).

As with other broad spectrum antibiotics, colitis, including rare instances of pseudomembranous colitis, has been reported in conjunction with therapy with Cefaclor.

Hypersensitivity reactions have been reported in about 1.5 percent of patients and include morbilliform eruptions (1 in 100), Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients. Cases of serum sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthritis and, frequently, fever) have been reported. These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Cefaclor (cefactor). Such reactions have been reported more frequently in children than in adults. Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy. No serious sequelae have been reported. Antihistamines and corticosteroids appear to enhance resolution of the syndrome.

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy.

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients).

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported. Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician.

Hepatic—Slight elevations in SGOT, SGPT, or alkaline phosphatase values (1 in 40).

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40).

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200).

[1002291R]

***Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S. pneumoniae* or *H. influenzae*.**

Note: Cefaclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients.

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever. See prescribing information.

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Some ampicillin-resistant strains of *Haemophilus influenzae*—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Cefaclor.¹⁻⁶

In clinical trials, patients with bacterial bronchitis due to susceptible strains of *Streptococcus pneumoniae*, *H. influenzae*, *S. pyogenes* (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Cefaclor.⁷

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285.

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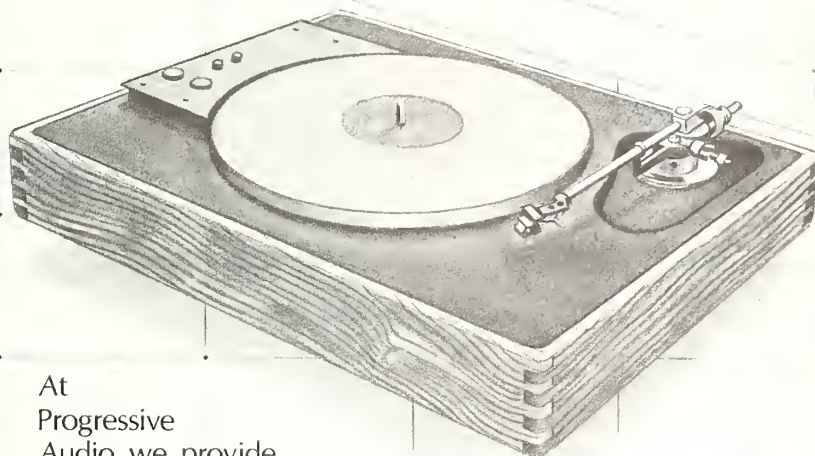
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If you've been one of those cursing technology as today's current "bane of existence," maybe it's time you took another look at the computer. As the OSMA discovered, expansion and advancement are inevitable. And so, you may find, is the computer.

Kären, S. Edwards is the Executive Editor of the Ohio State Medical Journal.

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—ALBERT EINSTEIN

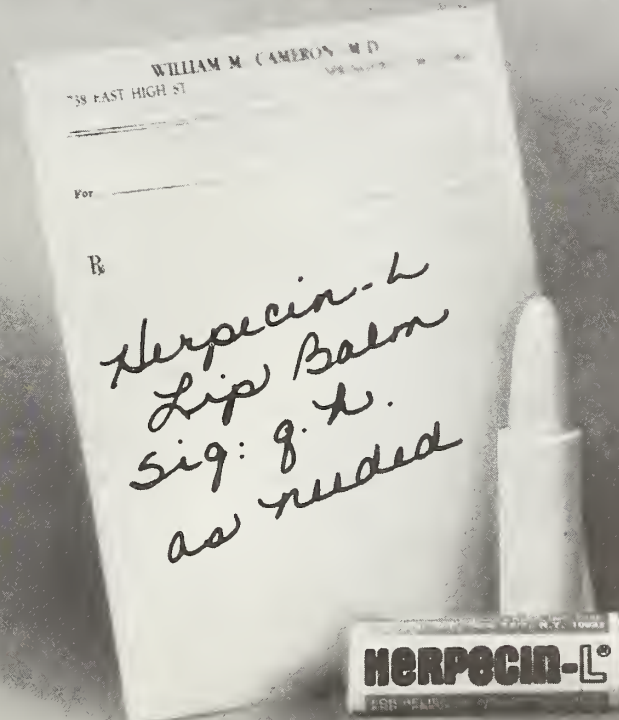


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MEDICAL ADVANCES

“When I first began my practice, a radiologist was viewed as someone who sat around and looked at X-rays all day.” But times have changed.

Radiology

From X-rays to Alphabet Soup

By Gina DiBlasio Cummins

True or false. Radiologists spend most of their time reading and interpreting X-rays for diagnostic purposes.

If you answered true, you would have been correct — ten years ago. The field of radiology has changed dramatically in the past decade. This branch of medicine that once was restricted solely to the diagnosis of a disease now is responsible for the treatment of patients as well. Keeping up with the radical changes that have taken place in the practice of radiology has been a welcome challenge to D. Kiefer Campbell, M.D., a Dayton radiologist and President of both the Ohio State Radiological Society and the OSMA Section of Radiology. Dr. Campbell has followed closely the metamorphosis of this field and discusses the great strides that have been made.

“When I first began my practice, a radiologist was viewed as someone who sat around and looked at X-rays all day. We contributed little, if anything, to therapy and had virtually

no patient contact. But radiology gradually has become much more exciting and challenging by affording those of us who desire it the opportunity to become Interventional radiologists — in other words, true clinical physicians who apply our technical knowledge to our practice.”

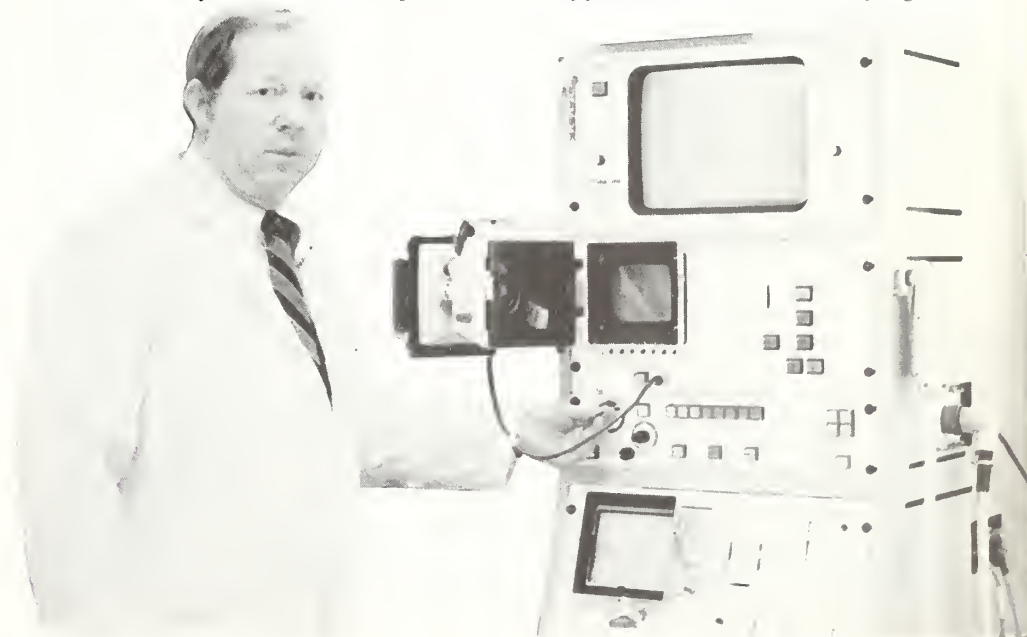
He explains that the application of this technical knowledge has been made possible by intense ongoing research and the development of numerous sophisticated techniques

and procedures which have revolutionized this field in the past decade.

“In fact, radiology is starting to sound a lot like alphabet soup with its many computerized procedures such as the CT (computerized tomography) scan, the NMR (nuclear magnetic resonance), PET (positron emission tomography) scan and the DVI (digital vascular imaging).

Dr. Campbell explains that in order to appreciate the unbelievable progress

D. Kiefer Campbell, M.D., Dayton, demonstrates the electrocardiograph (EKG) which records the heart's activity.



Radiology. From X-Rays to Alphabet Soup

this field has made in just five years, it is vital to understand the capabilities of several of the more commonly used procedures that follow:

- Ultrasound

Ultrasound is an imaging procedure that is most commonly used for dating pregnancy or detecting problems during pregnancy. "For instance, if a physician does not think that a fetus is growing properly, a radiologist can take the fetus' measurements inside the womb with the Ultrasound's imaging process. A sound beam is projected into the patient and the data is recorded into a computer." Dr. Campbell explains that it works on the same principle as sonar in a submarine. He notes that Ultrasound's biggest advantage is that it produces minimal risk to the fetus because it does not require radiation.

- Zeromammography

This is another imaging technique strictly used to evaluate the breast for disease. A Xeromammography is 95 percent reliable and can detect lumps in the breast, determine whether or

not masses in the breast are malignant or benign, etc.

- CT scanner

The CT scanner is a speedy diagnostic procedure that can X-ray any part of the body. "It is the only diagnostic tool available that can produce a three-dimensional image and transectional view of a body part," notes Dr. Campbell. A computer prints out the image of an X-rayed area on the CT scanner screen. "For instance, if a subdural hematoma is suspected, the CT scanner can take 10 one-centimeter slices of the brain at two seconds per slice and make a risk-free diagnosis in minutes." He says that the CT scanner can be used for many other purposes including an evaluation of the pancreas, and for detecting enlarged lymph nodes and tumors.

- Angioplasty

This procedure is done by inserting a balloon into the artery, dilating the area of stenosis and thereby can prevent the necessity of vascular surgery.

- DVI

The DVI is used mainly to evaluate carotid bifurcation disease in the patient with an asymptomatic carotid bruit for a questionable TIA (transient ischemic attack).

- Percutaneous nephrostomy

This technique uses needles, wire and catheter to drain urine from the kidneys. It is used most commonly when a patient's ureters have become involved by a tumor. This procedure also can be used to drain fluids from other parts of the body, hematomas, cystic fluids and abscesses. This same type of procedure can be used to remove gallstones from the common duct.

The use of better catheters, nontoxic solutions and better equipment has made a risky procedure relatively safe.

- Angiography

Dr. Campbell says that although this is an old procedure, it has been updated over the past several years. The use of better catheters, nontoxic solutions, and better equipment has made what used to be a risky procedure, a relatively safe invasive form of surgery.

He notes that a newer branch of radiology, called nuclear cardiac radiology, also has developed several noteworthy scanning techniques. The most noteworthy, a procedure called thallium scanning, has been devised to evaluate the condition of the heart muscle. After injecting thallium into the body and using a nuclear medicine camera, radiologists can watch the isotope collect and count how much of the isotope is collected in the heart muscle. "In a couple of hours, we can see if the isotope has changed its distribution. Among other things, the various changes can indicate whether or not the heart has suffered any

continued on page 849



Images being processed into the CT scan appear on the scanner TV screen.

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The Physician's Sleep Glossary

Some common sleep laboratory terms

poly·som·no·graph. An instrument which simultaneously records by electrodes physiological variables during sleep—for example, brain activity (EEG), eye movements (EOG), muscle tonus (EMG) and other electrophysiological variables. These readings indicate precisely when patients fall asleep, how many wake periods they experience, the quality of sleep and the duration of sleep.

sleep la·ten·cy. The period of time measured from "lights out," or bedtime, to the commencement or onset of sleep.

wake time af·ter sleep on·set. Intervals of time spent awake between onset of sleep and the end of the sleep period. The polysomnograph registers the length and frequency of the intervals.

to·tal sleep time. The amount of time actually spent in sleeping. This is estimated by subtracting wake times from the period encompassed by the onset and the termination of sleep.¹

REM/NREM. 1. REM, or rapid eye movement, sleep is "active"—characterized by increased metabolic rates, elevated temperature and arousal-type EEG patterns. 2. NREM, or non-rapid eye movement, sleep represents "quiet" sleep stages. There are four distinct stages of NREM sleep.²

re·bound in·som·nia. A statistically significant worsening of sleep compared to baseline on the nights immediately following discontinuation of sleep medication.³

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Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, light-headedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, e.g., excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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Obituaries

DAVID S. ARBUCKLE, M.D., Tryon, North Carolina; University of Toronto Faculty Medicine, Toronto, Ontario, 1923; age 86; died September 19, 1982; member OSMa and AMA.

JAMES W. CALVERT, M.D., Miami Lakes, Florida; Indiana University School of Medicine, Indianapolis, 1927; age 80; died August 21, 1982; member OSMa and AMA.

MERLIN L. COOPER, M.D., Cincinnati; University of Cincinnati College of Medicine, 1928; age 89; died October 10, 1982; member OSMa and AMA.

ARMANDO F. FAJARDO, M.D., Lima; University de la Habana, LaHabana, Cuba, 1943; age 64; died September 12, 1982; member OSMa and AMA.

LEON S. HIRSH, M.D., Pensacola, Florida; University of Louisville School of Medicine, 1931; age 74; died September 26, 1982; member OSMa.

ABRAHAM H. KANTER, M.D., Columbus; Eclectic Medical College, Cincinnati, 1929; age 77; died September 24, 1982; member OSMa and AMA.

WALTER H. PRITCHARD, M.D., Cleveland; Harvard Medical School, Boston, 1936; age 72; died September 2, 1982; member OSMa and AMA.

FREDERIC SCHNEBLY, M.D., Dayton; Temple University School of Medicine, Philadelphia, 1948; age 59; died October 10, 1982; member OSMa and AMA.

JAMES MILTON SHAW, M.D., Cleveland; Ohio State University College of Medicine, 1957; age 52; died October 12, 1982; member OSMa and AMA.

MYRON H. STEINBERG, M.D., Youngstown; Ohio State University College of Medicine, 1934; age 91; died January 21, 1982; member OSMa and AMA.

JOSEPH M. STRONG, M.D., Elyria; Case Western Reserve University School of Medicine, 1935; age 73; died September 19, 1982; member OSMa and AMA.

GEORGE O. THOMPSON, M.D., Alliance; Case Western Reserve University School of Medicine, 1928; age 81; died May 13, 1982; member OSMa and AMA.

RAY A. VAN OMMEN, M.D., Hilton Head Island, South Carolina; University of Michigan Medical School, 1945; age 62; died October 15, 1982; member OSMa and AMA.

OWEN F. YAW, M.D., Logan; University of Cincinnati College of Medicine, 1939; age 71; died August 27, 1982; member OSMa and AMA.



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Lawrence L. Wilbers
Horatio C. Wood IV
Colin Zadikoff

HIGHLAND

Adil Y. Yamour, Greenfield
Beverly Yamour, Greenfield

MUSKINGUM

Roland V. Long, Zanesville
Michael J. Somple, Zanesville

OTTAWA

Glenn Trippe, Port Clinton

PORTAGE

Philip Kennedy, Streetsboro

ROSS

Jack Berno, Chillicothe
John L. Fortney, Columbus
David P. Keseg, Chillicothe

SCIOTO

Wayne B. Wheeler, Portsmouth

SUMMIT (Akron unless noted)

Ian G. Dresner, Cleveland
Boni Elewski
Richard W. Lobritz
Dale Murphy

WILLIAMS

William D. Harvey, Bryan

CONTINUING EDUCATION PROGRAMS



Sixth Annual Continuing Education Pediatric Update. January 27-February 5, 1983. Rose Hall Intercontinental Resort, Jamaica. An educational program combining clinically oriented information and innovative approaches to areas of medical practice and research. Contact Harold Lubin, M.D., Children's Hospital, 700 Children's Drive, Columbus, Ohio 43205.

Pediatric Dermatology Seminar X. February 24-27, 1983. The Carillon Beach Hotel, Miami Beach, Florida.

Guest speakers include: Yehudi Felman, Arthur Norins. For information, contact: Guinter Kahn, M.D., 16800 N.W. 2 Ave. No. 401, Miami, Florida 33169.

Adolescent/Young Adult Medicine. February 23-March 1, 1983. Wailea Beach Hotel, Maui, Hawaii. 20 hours Category I. For further information, contact the Hurley Medical Center, Department of Continuing Medical Education, One Hurley Plaza, Flint, Michigan 48502.



CLINICAL NOTES

Edited by Karen S. Edwards

Chronic active hepatitis and pregnancy

Chronic active hepatitis (CAH), especially in the presence of cirrhosis, often leads to amenorrhea and infertility. Spontaneous or corticosteroid-induced remission has resulted in an increased number of young women with this disorder not only conceiving but surviving pregnancy.

The course and outcome of CAH during and after pregnancy is extremely variable. The outcome of pregnancy in two adolescents is described. Pregnancy was uneventful in both patients, apart from mild biochemical deterioration in one patient. Both infants are normal. One mother died 4 1/2 months after delivery from primary pulmonary hypertension, an extra-hepatic manifestation of her chronic active hepatitis. The second patient is asymptomatic but has evidence of ongoing liver disease 26 months postdelivery.

Management of CAH with prednisone and addition of Azathioprine, if needed, is definitely improving the life expectancy of patients from the time of diagnosis. The consensus, however, is that many of these young women may not live to see their children's second decade.

—The American Journal of Gastroenterology
September, 1982, Volume 77, Number 9
pgs. 649-651

Bed-sharing between parents and children

A survey of 415 upper middle class parents of 576 children revealed that, when the children awoke ill or frightened, the parents commonly took the child into their bed, despite advice from some experts that if parents take their frightened child into bed with them, there will be the "devil to pay."

Possibly, however, too much attention may have been paid to the events, such as parents and children sharing a bed, and not enough attention has been devoted to the context, motivation and setting in which these events occur.

Complex behaviors in a family must be investigated and thought about in more sophisticated ways. "Motivation" and "setting" are aspects of parental attitudes that may be as critical to pathogenicity as the act itself. If, in any given case, a child's being in the parental bed does give rise to psychopathology, clinicians must consider whether being in bed with the parent is per se the cause, or whether the child's being in bed reflects: (1) deeper problems in the whole fabric of family relationships; (2) ego defects in the child; (3) parents' use of the child for their own ends. In these situations, the child's being in bed may be but one small rent indicative of much deeper defects in the fabric of family life. Ultimately, the clinician must address this overall fabric. What its rents are, how they come about, and how they can be prevented will become clearer as more careful studies of children and families are completed.

Archives of General Psychiatry
Volume 39, Number 8, August, 1982
pgs. 943-947

Similarities in aging and enforced physical inactivity

A review of biologic changes commonly attributed to the process of aging demonstrates the close similarity

of most of these to changes subsequent to a period of enforced physical inactivity. The coincidence of these changes from the subcellular to the whole-body level of organization, and across a wide range of body systems, prompts the suggestion that at least a portion of the changes that are commonly attributed to aging is, in reality, caused by disuse, and is subject to correction.

Some of the similarities in changes noted are: loss of lean body mass and body weight; calcium wastage; disordered sleep patterns; deteriorative changes in sense organ functioning; behavioral alterations, particularly depression; and deterioration of the immune system.

Although it cannot be presumed that physical inactivity is the cause of the aging process, or that exercise might halt the fall of the grains of sand in the hourglass, it is proposed that a physically active life may allow us to approach our true biogenetic potential for longevity.

The new science of space medicine has greatly expanded our understanding of the morbid physiology of enforced rest and weightlessness. By looking beyond ourselves, we are discovering more about what we are within, and by ensuring fitness, physical and mental, we may maintain our functional integrity and vigor, and thereby approach the idealized square-edge existence to which we all aspire.

The Journal of the American Medical Association

Volume 248, No. 10, September 10, 1982
pgs. 1203-1208

Drug treatments for heart patients

In today's polypharmacy, the physician is still confronted with best choices. Many patients who have heart failure are treated with beta blockers because of hypertension or angina. These agents tend to produce some degree of heart failure. Should this tendency be counteracted with administration of digoxin? Some patients with refractory heart failure

are treated with vasodilator drugs. In this case, the relative merit of adding digoxin or maintaining it in the patient's regimen remains to be established.

It is clear that the toxicity potential of digitalis is considerable, while the expected benefit is small when the heart rhythm is regular and diuretics are adequately used. The clinician should not persist in using digitalis when there is no demonstrable clinical benefit.

—**American Family Physician**
Volume 26, No. 2, August, 1982
pgs. 217-218

Diethyltoluamide danger

The U.S. Department of Agriculture has called diethyltoluamide the best all-purpose insect repellent so far developed. It is available in concentrations of less than 1% up to 50% in a number of commercial forms: sprays, liquids or stick for application to the skin or bedclothes.

During the summer of 1978, however, ten soldiers were treated for an eruption in the antecubital fossae. All of them had used an insect repellent containing 50% diethyltoluamide several hours before the eruption had appeared. The symptoms were those of a burning sensation, erythema and blisters at the onset, followed in some cases by ulceration and scarring.

Since 1961, three cases of toxic encephalopathy from diethyltoluamide have been reported in children. Shaking and crying spells, slurred speech and confusion developed, improving after vigorous medical treatment that included anticonvulsive therapy.

Diethyltoluamide is in extensive worldwide use today. Despite its popularity, few cases of local or systemic toxic effect have been reported. This may be partly due to physicians' lack of awareness of its toxic manifestations, resulting in an "iceberg" type of epidemiologic phenomenon.

In view of its considerable value as

an insect repellent and its overall low incidence of toxic effect, the use of diethyltoluamide will continue.

Prolonged use in children or application to the antecubital fossa, however, should certainly be avoided.

—**Archives of Dermatology**
Volume 118, No. 8, August, 1982
pgs. 582-583

Drug-induced parkinsonism

Parkinson's syndrome was first noted in patients treated with neuroleptic drugs in the early 1950s. As the use of more potent phenothiazines and butyrophenones became widespread, drug-induced parkinsonism (DIP) became a well-recognized side effect of these drugs. The pathophysiologic basis for the individual susceptibility to DIP has not been explained.

This report looks at the clinicopathologic study of two cases of drug-induced parkinsonism. In each case, the clinical manifestations remitted completely when the offending drug or drugs were discontinued. Histologic examination in each patient disclosed abnormalities characteristic of idiopathic paralysis agitans (IPA). It is postulated that, before administration of neuroleptic drugs, both patients had preclinical IPA which predisposed them to parkinsonism when challenged with dopamine antagonists.

The authors' observations suggest that some patients with irreversible drug-induced parkinsonism may suffer from IPA and that the reversibility of clinical features does not exclude the presence of subclinical IPA. Although IPA remains the largest single subgroup, postencephalitic parkinsonism now has been replaced by DIP as a second leading form of Parkinson's syndrome. The nature of individual susceptibility, which is so crucial in the production of DIP, has not been elucidated to date, but perhaps more interest in understanding DIP will be generated.

—**Archives of Neurology**
October, 1982, Vol. 39; No. 10
pgs. 644-647

Radiology. From X-Rays to Alphabet Soup

continued

damage (if the patient has had a heart attack), and whether coronary bypass surgery would be helpful."

Hepatobiliary scanning has been developed which can examine other parts of the body for disease. It has been helpful in determining whether or not a patient has gall bladder disease, if gallstones are obstructing the common duct, etc.

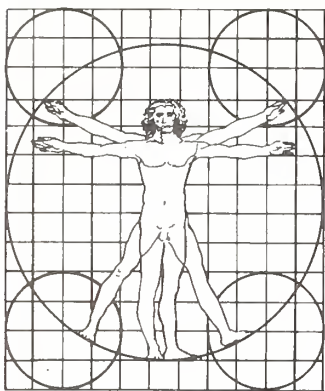
Dr. Campbell says that the two computerized procedures mentioned earlier — the NMR and the PET scan, currently are being perfected and probably will be widely used in the next five and ten years respectively. "If we can overcome the NMR's biggest disadvantage — its \$1.3 million price tag per machine, it will be a fantastic way to examine the spinal cord." The NMR measures a person's radio frequency in the presence of a strong magnetic field. The computer then prints out a picture of the area under examination to check for disease.

Dr. Campbell notes that besides the term "PET scan" becoming a household word in the next ten years, he expects a multitude of other technological advances to invade the field of radiology. "This field is going to be like Star Wars — there's going to be such a rapid increase in computer technology and newer procedures being developed that we'll be able to examine the body in 50 different ways!"

He explains that in order to keep up with this rapid growth, radiologists will not only have to become experts in computers and imaging procedures, but knowledgeable in electrical, sound and optical physics as well.

"There are so many exciting possibilities on the drawing board that the field of radiology is literally going to take off in the next decade — and if we as radiologists are unwilling to change as quickly as this field, we won't be doing anything."

Gina DiBlasio Cummins is Editor of Synergy and a staff writer for the Ohio State Medical Journal.



CLINICAL & SCIENTIFIC

THE VERTICAL LAMINAR AIR FLOW SYSTEM AT MOUNT CARMEL MEDICAL CENTER — A SECOND LOOK

Karl C. Saunders, M.D.

Thomas L. Meyer, Jr., M.D.

Hugo A. Cabrera, M.D.

A vertical air curtain laminar flow system has been in use at Mount Carmel Medical Center for the purpose of a "clean air room." A study utilizing settle plates was undertaken to determine the effectiveness of this system in reducing airborne contamination. A comparison was made between 95 cases in laminar flow and 97 cases in conventional rooms. Containment gowns with helmet aspirators also were studied. The results support the use of containment gowns and helmet aspirators, but indicate that the laminar flow system evaluated was no more effective in reducing airborne contamination than were the conventional rooms utilized in the study.

THERE HAS BEEN MUCH DISCUSSION in the literature about laminar air flow units for total joint replacement surgery. Although there still remains some question as to the effectiveness of such units in preventing wound infection, various types of laminar air flow systems have been installed throughout the world.

In 1972, a vertical ceiling-mounted unidirectional flow system was installed at Mount Carmel Medical Center. The unit has since been in operation for the purpose of a "clean air room" except for shutdown times for maintenance, and in 1976, when the system was relocated. This study was under-

taken to assess the effectiveness of this laminar flow system in reducing airborne contamination. In addition, the effectiveness of containment gowns with helmet aspirators was evaluated.

Materials and Methods

To assess the quality of air circulating in an operating room, 5% sheep's blood agar culture plates were prepared for the purpose of settle plates. These agar plates were ethylene oxide sterilized and packaged for use in the operating room. Two plates were assigned for each orthopedic case. Plate "A" was attached to the drapes on the operating field near the surgeon. Plate "B" was placed on the nurse's instrument table.

Following skin preparation and draping, these plates were opened and exposed for one hour. The plates then were closed, sent to bacteriology, and incubated at 35 to 37 degrees for 48 hours. The number of colonies present on each plate was recorded. An air quality form (Fig. 1) was completed for each set of plates. Each form included the patient's addressograph information, date of surgery, surgeon and assistants' names, and operating room number. The use of containment gowns with helmet aspirators was recorded. Any complications in exposing or handling of the culture plates were noted. Complications which were cause for exclusion included improper time exposure, agar separation from the plate, and irrigation solution entering the plate during surgery. Of 203 orthopedic cases completed, 11 were excluded due to these complications. Remaining for analysis were 192 cases, 95 in the clean air room, and 97 in conventional operating rooms.

The unidirectional flow system in the clean air room at Mount Carmel Medical Center is a ceiling-mounted air curtain unit with inner and outer chambers. Slots in the outer chamber create an air curtain effect between the ceiling and the floor, isolating this space from the rest of the room. Filtered air to the inner zone is provided through perforated channels of the inner chamber. A damper controls the balance of inner and outer chamber air. The system is designed to provide 60 to 70

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Submitted June 1, 1981.

air changes per hour. High efficiency particulate air (HEPA) filters removing 99.9% of all particles 0.3 microns and larger, are part of the installation. Two surgical lighting fixtures are present beneath the ceiling unit.

Eight conventional operating rooms also were utilized for the study. These rooms have an average of 25 air exchanges per hour. All rooms have filtered air systems, and the six perimeter rooms have HEPA filtering systems.

All operating rooms, including the laminar flow room, have a service and maintenance plan. At the time of this study all rooms involved were operating satisfactorily with no identifiable maintenance problems.

Results

Ninety-five cases were done under laminar flow and 97 cases were done in conventional operating rooms without laminar flow (Fig. 2). Seventy-eight cases (82.1%) in laminar flow and 86 cases (88.7%) in rooms without laminar flow had positive colony counts on either Plate A or Plate B (Fig. 3).

When containment gowns with helmet aspirators were used in the laminar flow room (45 cases), 75.6% of cases had positive colony counts, a significantly lower figure ($p<.10$) (Fig. 4). When comparing the percentage of cases with positive counts in conventional rooms versus those done in laminar flow without containment gowns and helmet aspirators, there was no significant difference (Fig. 5).

Comparison also was possible between settle plates placed on the operating field and those placed on the nurse's instrument table (Fig. 6). A significantly lower number of plates ($p<.01$) were positive at the operative field in the laminar flow room when containment gowns and helmet aspirators were used.

These results indicate that when containment gowns with helmet aspirators were not used, there was no significant difference in the number of positive plates between the laminar flow room and conventional operating rooms. The use of exhaust gowns and helmets in the laminar flow room provided a significant drop in the number of positive plates at the operative field, but there was no significant difference at the instrument table. The number of positive plates was higher at the operative field than at the instrument table in the laminar flow room when containment gowns and helmets were not used.

Discussion

A ceiling-mounted unidirectional flow system has been in service at Mount Carmel Medical Center for the purpose of providing a clean air room. This room is used largely for total joint replacement surgery. With the advent of newer laminar flow systems, particularly horizontal units, questions have been raised regarding the effectiveness of the present system.

Although the clean air room was functioning without known problems at the time of this study, previous maintenance problems have been significant. In 1979, an analysis by a professional air control firm recommended keeping the lighting fixtures within the air curtain, cleaning the lighting fixtures regularly, cleaning the exhaust and air grilles regularly, changing the HEPA filters, and keeping all members of the operating team, including anesthesia, within the inner zone. Also, after a case begins, the thermostat was not to be changed because of temporary interruptions of air patterns. The operating room doors were to be kept closed and traffic limited as much as possible. All of these recommendations were implemented.

To assess the microbiologic quality of air circulating in the

FIGURE 1: AIR QUALITY STUDY FORM

ADDRESSOGRAPH: _____

You should have (2) sterile culture plates for each case. Plate "A" should be attached to the drapes on the operating field. Plate "B" should be placed on the scrub nurse's back table. The plates should be exposed for exactly one hour. Then this form and the culture plates should be taken to the front desk where they will be logged and sent to Dr. Cabrera in bacteriology.

DATE _____

PROCEDURE _____

SURGEON _____ ASSISTANTS _____

OPERATING ROOM # _____

EXHAUST GOWNS & HELMETS USED? (yes) (no)

ANY COMPLICATIONS WITH PLATES? _____

Information below to be completed by Bacteriology:

COLONY COUNT: PLATE A _____

PLATE B _____

FIGURE 2: LOCATION OF OPERATIVE CASES

192 TOTAL CASES
95 LAMINAR FLOW — ROOM 14
97 CONVENTIONAL ROOMS

Room #	# of cases
1	5
2	6
3	14
4	16
9	5
10	9
12	15
15	27

FIGURE 3: POSITIVE COLONY COUNTS ON EITHER PLATE A OR B

LAMINAR FLOW ROOM	78/95	(82.1%)
CONVENTIONAL ROOMS	86/97	(88.7%)

FIGURE 4: LAMINAR FLOW ROOM RESULTS

	# of cases	% of cases + (A or B)
EXHAUST GOWNS/ HELMETS	45	34/45 = 75.6%
NO EXHAUST GOWNS/HELMETS	50	44/50 = 88.0%

moderately significant
($p < .10$)

FIGURE 5: % OF CASES WITH POSITIVE COUNTS
(A OR B)

LAMINAR FLOW ROOM WITHOUT GOWNS/HELMETS	88.0%
CONVENTIONAL ROOMS	88.7%
(insignificant)	

FIGURE 6: COMPARISON OF OPERATIVE FIELD (A) &
INSTRUMENT TABLE (B)

	# (+) ON A	%	# (+) ON B	%
LAMINAR FLOW ROOM	62/95	65.3%	54/95	56.8%
CONVENTIONAL ROOMS	74/97	76.3%	74/97	76.3%
LAMINAR FLOW ROOM WITH GOWNS/ HELMETS	23/45	51.1%*	23/45	51.1%
LAMINAR ROOM WITHOUT GOWNS/ HELMETS	40/50	80.0%*	30/50	60.0%

*difference highly significant ($p < .01$)

operating rooms, settle plates were utilized in this study. The results indicate that there was no significant difference in the number of positive plates between the laminar flow room and conventional operating rooms when containment gowns with helmet aspirators were not used. The use of the exhaust gowns and helmets in the laminar flow room provided a significant drop in the number of positive plates at the operative field, but no significant change at the instrument table.

Charnley first introduced the idea of a "greenhouse" with a ceiling-mounted laminar flow system to improve the operating room environment for total joint replacement.¹ This concept laid the groundwork for future development and refinement in the control of airborne bacteria. His concern regarding local laminar air-flow turbulence due to personnel and lighting fixtures, possible contamination of ceiling HEPA filters when air-speed is reduced, and permeability of surgical gowns to hot air rising from the surgeon's body, led to the development of body exhaust systems with impermeable gowns and helmet aspirators.² These innovations were followed by a decrease in infection rate in Charnley's series from 7% in 1960 to about 0.5% in 1970,³⁻⁵ although one wonders if other factors such as increasing experience (most cases performed by surgeons in training), foam pressure pads to control hematoma, change in laminar flow from 130 to 300 exchanges per hour, changes in surgical technic, and better preoperative and postoperative care could not have played a role. Prophylactic antibiotics were not used in these series. Charnley believed the exhaust gowns and helmets to be responsible for the lowering of his infection rate from 1.5% with laminar flow alone to 0.5%, and concluded that this system effectively isolated the operating personnel and their debris (estimated at 10 mg to 20 mg per person per case) from the wound. An additional effect noted was the sense of well-being in these gowns, described by Charnley as exhilarating and like the effect of a Turkish bath.³

Other authors⁶⁻⁸ proceeded with further studies and likewise concluded that laminar air flow does indeed reduce airborne contamination. Nelson,⁹ Amstutz,¹⁰ and others¹¹⁻¹³ have suggested that airborne microorganisms originate almost exclusively from personnel within the room and from the patient. Laminar flow systems were found to markedly decrease this airborne bacterial concentration, and further reductions were seen with the use of containment gowns and helmet aspirators.¹⁴⁻¹⁶ Eftekhari¹⁷ in 1973 reported a 0.5% infection rate of 800 cases without laminar flow but with strict traffic control and the use of prophylactic antibiotics. However, he emphasized the need for impermeable gowns with body exhaust systems in an enclosure, effectively isolating personnel from the surgical field without an emphasis on laminar flow. The use of tracer particles has identified "patient-derived particles," and "surgeon-derived particles" in the majority of all wounds,¹³ and has underscored the importance of proper patient draping and isolation of the surgeon and staff with exhaust systems.

Charnley,^{4,5} Nelson,⁹ and others have suggested that the use of laminar flow and containment gowns with helmet aspirators lead to a decrease in postoperative wound infection. However, there has been a lack of firm data to confirm that a decrease in airborne contamination is directly linked to a decrease in postoperative infection. Studies evaluating this have had many deficiencies, including lack of controls, numerous variables, and numbers not of the magnitude to have statistical significance.^{15,18-21}

Both horizontal and vertical laminar flow systems have been studied. Considerable evolution of these units has occurred, and most systems now recirculate air at a rate of 300 or more

times per hour. There are proponents of vertical units,^{22,23} and those who advocate the more commonly installed horizontal units.^{24,25}

Regardless of the type of flow system, proper care and maintenance is mandatory. The ability to control airborne contamination should not lessen the awareness of strict basic aseptic technic.

Summary

Although the link between airborne contamination and wound infection still is not well defined, it seems prudent to reduce all potential sources of wound infection in total joint replacement surgery. To determine the effectiveness of a ceiling-mounted unidirectional air flow system in reducing airborne contamination, a study using settle plates was undertaken. The results indicate that the present air curtain system was no more effective in reducing airborne contamination as determined by positive settle plates than were conventional rooms. The use of containment gowns with helmet aspirators provided a statistically significant decrease in the number of positive settle plates at the operative field. These findings strongly support the use of exhaust gowns and helmets, but indicate that our laminar air flow system is no more effective in reducing airborne contamination than were the conventional rooms utilized in this study.

Acknowledgement: The author would like to thank Mrs. Susan Hakola and Mr. John Danyi for statistical analysis, and the operating room personnel at Mount Carmel Medical Center for their assistance.

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How to have your cake . . . and eat it too!

A synthetic calorie-free fat substitute used to reduce weight in a short-term study of 10 hospital patients under controlled metabolic conditions now is being tested on an outpatient basis.

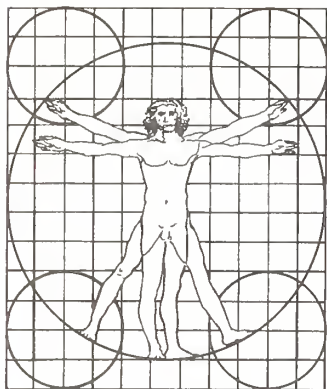
The sucrose polyester substance, which University of Cincinnati researcher Charles J. Glueck, M.D., said tastes, looks and smells like

common cooking fats, was substituted for conventional fats in salad dressings, bread spreads and milkshakes during the double-blind study.

The result was weight loss averaging nearly .4 pound per day. Total caloric intake, including snacks, fell 23% during the period study subjects were

receiving the nonabsorbable sucrose polyester.

If further study continues to show promising results, it could be an ideal food additive for relatively quick weight loss of 5 or 10 pounds, he said, but more data are needed to warrant Food and Drug Administration approval.



CLINICAL & SCIENTIFIC

RECURRENT PEPTIC ULCER DISEASE 1969-1980

Richard W. Zollinger II, M.D.

John J. Ferrara, M.D.

Patrick S. Vaccaro, M.D.

Larry C. Carey, M.D.

Of 112 patients undergoing 146 operations for recurrent peptic ulcer between 1969 and 1980, 25% had a second recurrence, and 5% a third. Most recurrences were duodenal, although one third of the patients requiring three operations had marginal recurrences. Mean time to recurrence was five years, but was less than one year or more than five in most. Pain was the most common symptom, followed by bleeding. Most first ulcers had been detected radiographically, but recurrences were most accurately detected endoscopically. Only two patients had ulcerogenic tumor. Ninety-one patients with first recurrences had acid studies; 35 had a basal acid output of less than 2 mEq/hr, while 16 had no measurable basal acid. Acid studies were less helpful than anticipated. Operations that ultimately controlled recurrences were vagotomy and pyloroplasty in 34%, vagotomy and antrectomy in 28%, partial gastrectomy with Billroth I or Billroth II anastomoses in 32%, and various procedures from Roux-en-Y reconstruction to total gastrectomy in 6%. Mortality was 6% (7/112). Incomplete vagotomy appears to be responsible for recurrence of ulcers, with 107 of the 112 patients ultimately requiring repeat vagotomy.

ALTHOUGH THE INCIDENCE of peptic ulcer disease is declining in the United States, recurrent peptic ulceration continues to present serious problems. The authors retrospectively reviewed the records of 112 patients who underwent 146 operations for recurrent peptic ulcer disease between 1969 and 1980 to evaluate symptoms and treatment, as well as the location of recurrence and the time that elapsed between primary operation and recurrence. Primary operations performed in other hospitals were reviewed in a search for a common denominator in recurrences.

Of the 112 patients, 78 were men and 34 women, and their average age was 46 years. The mean period of time to recurrence was five years, although in most patients it was less than one or more than five years after the primary operation. Twenty-eight patients (25%) had a second recurrence, and six (5%) had a third recurrence.

Review of the records of referring physicians showed that in 64% of cases, the initial diagnosis had been duodenal ulcer, and in 23% the ulcer was gastric. In 13% of cases, the initial ulcer location was unknown. Primary procedures performed by referring surgeons in the 72 patients with duodenal ulcer had been vagotomy and drainage in 60%, gastroenterostomy only in 15%, and vagotomy and antrectomy in 5%. In over 35% of patients with duodenal ulcer, no initial vagotomy had been done as part of the primary operative procedure. Of the 24 patients with gastric ulcer, 40% had had oversew of a hemorrhaging or perforated ulcer, 35% had had vagotomy and drainage, and 20% a partial gastrectomy and drainage. Only 5% had had vagotomy and antrectomy as the initial procedure. However, 40% of patients with gastric ulcer had had a vagotomy as part of the initial operative procedure.

On admission to our hospital, 51% of the patients were found to have duodenal recurrences, 28% had gastric recurrences, and 13% had a marginal ulcer. In the remaining 8%, recurrent ulcerations were present in various locations throughout the gastrointestinal tract.

Procedures performed at our hospital that ultimately resulted in the cure of recurrent peptic ulcerations were vagotomy and drainage in 34%, vagotomy and partial gastrectomy with a Billroth I or Billroth II anastomosis in 32%, and vagotomy and antrectomy in 28% (see table). In the remaining 6% of patients, gastroenterostomy only was performed in 2%,

From the Department of Surgery, The Ohio State University College of Medicine, 410 West Tenth Avenue, Columbus, Ohio 43210. Presented at the Residents' Meeting, The Annual Meeting of the Society of University Surgeons, Hershey, Pennsylvania, February 11, 1981.

Submitted September 15, 1981.

ULTIMATE PROCEDURE FOR RECURRENT ULCER 112 Patients

Procedure	Percent
Vagotomy & Drainage	34
Vagotomy & Partial Gastrectomy (Billroth I or Billroth II)	32
Vagotomy & Antrectomy	28
Gastroenterostomy	2
Total Gastrectomy	2
Oversew	1
Normal	1

total gastrectomy in 2% (both patients had the ulcerogenic tumor syndrome), oversew of perforation in 1%. One patient with recurrent marginal ulceration had takedown of a gastroenterostomy, and with the return to normal anatomic continuity, had no further recurrence of symptoms (see table).

Based on information obtained at follow-up examinations, 82% of the patients in this series had a good or improved result after their last operation, and 8% had a fair or poor result. Of the latter, the majority were shown by history and physical examination upon admission to our hospital to be chronic alcoholics. Only 10% of the patients were lost to further follow-up.¹

The major presenting symptom of recurrence in 65% of the patients was pain. Hemorrhage was the major symptom in 25%, and symptoms of obstruction were present in 20%. In fewer than 3% of patients with recurrent peptic ulcer was perforation the initial symptom.

The first ulcer had been diagnosed radiographically in most cases. Recurrences were diagnosed equally well with radiologic studies and endoscopic examination in half the patients. Gastrointestinal films proved to be less reliable than we had hoped because of postoperative distortion of anatomic continuity in patients with recurrent ulcer, whereas the increasing availability and improved design of the flexible fiberoptic endoscope increased the accuracy of diagnosis as the '70s progressed.² Laparotomy alone established the diagnosis of recurrent peptic ulcer in 20% of cases.

Acid studies were made in 91 of 112 patients before their first reoperation at our hospital. Of these, a basal acid output of 2 mEq/hr or less was shown in 35 patients, and 16 had no measurable acid output. It was concluded that results were within normal limits in more than half the acid studies performed, and therefore they were less helpful than anticipated in the diagnosis of recurrent peptic ulceration. Two of the patients had the Zollinger-Ellison syndrome.

The most commonly overlooked vagal trunk is the right posterior, and this proved to be the most common cause of a previously inadequate vagotomy. Of these 112 patients, 40% had not undergone vagotomy as part of their initial operation. Sixty-four patients had vagotomy at their first reoperation, 37 at their second, 4 at their third, and 2 patients did not have vagotomy until their fourth operative procedure.

In summary, recurrent ulceration was signaled most often by pain. Diagnosis was made equally well with gastrointestinal radiography and flexible fiberoptic endoscopy, although this became increasingly more accurate as availability and quality of the instrument improved over the '70s. Acid studies were less helpful than anticipated. The cause of the recurrence in the majority of patients was a previously inadequate vagotomy^{2,3} and 95% of the patients with either duodenal or marginal recurrent ulceration required a repeat vagotomy. Mortality in this series was 6%, higher than the expected mortality for an initial ulcer operation, and this underlines the gravity of recurrent ulceration.

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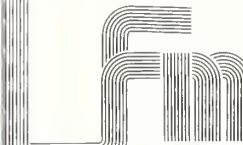
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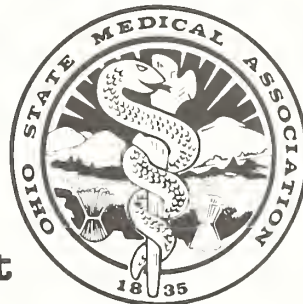
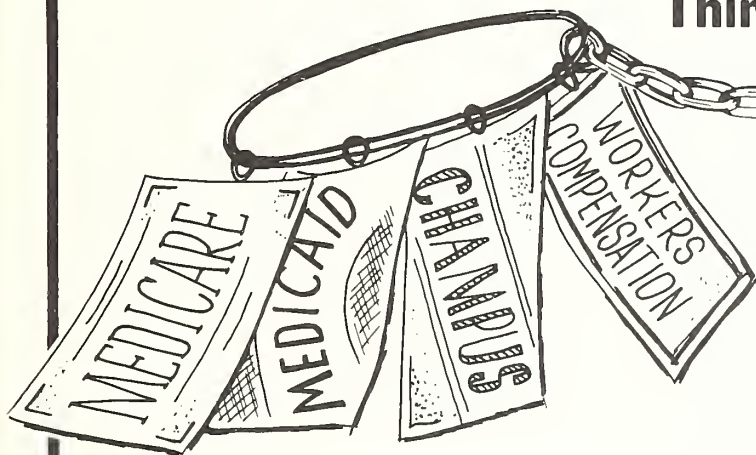
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